

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES



PHYSICIANS SERVICES PROVIDER MANUAL

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South Carolina Department of Health and Human Services

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PROGRAM OVERVIEW

The State of South Carolina (South Carolina or State) Medicaid program recognizes professional medical services that are medically necessary, unless limitations are noted within the Other Service Limitations section of this manual. Information in this manual includes South Carolina Medicaid policies for general medical care, such as, office exams.

These services are predominantly billed to Medicaid by Primary Care Physicians (PCPs), such as family physicians, internists, general practitioners, obstetricians/gynecologists (OB/GYN) and pediatricians. However, the guidelines are written for all providers rendering services to South Carolina citizens who are Medicaid beneficiaries.

Note: References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- [Provider Administrative and Billing Manual](#)
- [Forms](#)
- [Section 4 - Procedure Codes](#)

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ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

Physician

For Medicaid billing purposes, the term “physician” includes doctors of medicine and osteopathy who are currently licensed in the state in which they are rendering services by that state’s Board of Medical Examiners.

Hospital-Based Physician

A hospital-based physician is defined as a physician licensed to practice medicine or osteopathy who is employed by a hospital, and whose payment for services is claimed by the hospital as an allowable cost under the Medicaid program and billed by the contracted hospital.

Physician’s Assistant

A physician assistant (PA) may provide medically necessary covered services as long as the services provided are allowed by State Law and consistent with the agreement between the PA and the PA’s supervising physician. PAs providing services to Healthy Connections beneficiaries must be enrolled as South Carolina Medicaid providers.

Services rendered and billed under the PA’s individual National Provider Identifier (NPI) number are reimbursed at 80% of the current Medicaid Family and General Practitioners physician’s fee schedule for professional services.

Certified Nurse Midwife

A certified nurse midwife (CNM) must be licensed to practice as a Registered Nurse and as a CNM in the state in which he or she is rendering services. Services are provided under the supervision of a physician preceptor according to a mutually agreed-upon protocol. Reimbursement is 100% of the physician rate.

Licensed Midwife

A Licensed Midwife is defined as a person who is not a medical or nursing professional licensed by the South Carolina Department of Health and Environmental Control (SCDHEC), for the purpose of providing specifically defined prenatal, delivery and postpartum services to low-risk women. Reimbursement is 65% of the physician rate.

Certified Registered Nurse Anesthetist (CRNA)

A CRNA must be licensed to practice as a Registered Nurse in the state in which he or she is rendering services and currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. A recent graduate is a new graduate of an

advanced formal education program for nurse anesthetist accredited by the national accrediting organization who must achieve certification within one year of graduation. Upon obtaining certification, recent graduates must notify Provider Enrollment to continue practicing as a Medicaid provider. CRNAs may work under the medical direction of a surgeon or under the supervision of an anesthesiologist. CRNAs working under the medical direction of a surgeon or under the supervision of an anesthesiologist will be reimbursed at 50% of the physician rate. CRNAs not working under the direction of an anesthesiologist or supervised by a physician will be reimbursed 87% of the physician rate.

Anesthesiologist Assistant (AA)

An AA must be licensed to practice as an AA in the state he or she is rendering services. AAs may only work under the supervision of an anesthesiologist.

Dietitian

A dietitian is defined as any individual meeting the licensure and educational requirements in South Carolina and/or the border states of Georgia and North Carolina. All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). The SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

Paramedical Professionals

The following medical professionals may render services to Medicaid patients under the direct supervision of a licensed physician:

- Audiologists
- Speech pathologists
- Physical therapists
- Occupational therapists
- Licensed master social workers (LMSWs)
- Psychiatric nurse practitioners (NPs)
- X-ray or lab technicians
- Licensed respiratory therapists
- Nurse midwives
- NPs

Reimbursement will be made to the supervising physician or hospital where the professional is employed, and where the service is rendered, under the restrictions set forth in this manual. If any of these medical professional services are included in a hospital cost report, they cannot also be billed separately as professional services.

Certified Nurse Practitioner (CNP) and Clinical Nurse Specialist (CNS)

The CNP/CNS may enroll with South Carolina Medicaid and be assigned a Medicaid ID number if he or she meets all of the following criteria:

- Licensed to practice as a Registered Nurse,
- Licensed as a CNS/CNP in the state in which he or she is rendering services, and
- Practicing under a physician preceptor according to a mutually agreed-upon protocol.

CNP/CNSs may bill for services under their physician preceptor's NPI number or under their individual NPI number (NP + 4 digits).

The services they render are limited to those that are allowed under State Law and are documented in the approved written protocol.

Delegated acts and protocols that outline the scope of practice guidelines for NPs, CNMs, CNS or PAs should be current and available in the personnel file of the supervised practitioner. Upon submission of a claim, the rendering physician is attesting that the services have been accurately and fully documented in the medical record and that he or she assumes responsibility for the NP, CNM, CNS or PA. The claim also confirms that the provider has certified the medical necessity and reasonableness for the service(s) submitted to Medicaid for payment. This policy does not supersede State Law, as it relates to requirements, for off-site practice protocols that outline co-signature guidelines for PAs. These requirements can be found in Article 7, Section 40-47-955, of the South Carolina Physician Assistants Practice Act.

Services rendered and billed under the NP individual NPI number are reimbursed at 80% of the physician's fee schedule for Evaluation and Management (E&M) codes and all professional codes, and 100% for supplies and pathology services. Fee schedules are located on the South Carolina Department of Health and Human Services (SCDHHS) website at: <http://www.scdhhs.gov>.

Any CNP/CNS employed by a hospital will be ineligible to submit claims for his or her services, as these services are included in the hospital cost report.

To request a CNP/CNS Enrollment Form, contact Provider Enrollment at +1 888 289 0709.

Optician

An optician fits and dispenses corrective lenses for the correction of a person's vision.

Self-Employed Optometrist

A self-employed licensed provider who examines the eyes to evaluate health and visual abilities, diagnoses eye diseases and conditions of the eye and visual system, and provides necessary treatment such as eyeglasses and contact lenses.

Chiropractors

To qualify as a Medicaid provider for chiropractic services, an individual must be licensed by the South Carolina Board of Chiropractic Examiners as a Doctor of Chiropractic. In order to participate in the Medicaid Program, a chiropractor must enroll with Medicaid and receive a Medicaid ID number. Both individual chiropractors and chiropractic groups are eligible to enroll. For questions regarding enrollment, please contact Medicaid Provider Enrollment at: +1 888 289 0709.

Psychiatric and Counseling Services

Psychiatric and psychotherapy services must be prescribed by an individual listed below:

- Physician/Psychiatrist
- Psychiatric NP

SCDHHS will reimburse an eligible provider for covered psychiatric and psychotherapy services personally provided by the physician or NP or by an allied professional under the direct supervision of the physician/NP. Allied professionals rendering the service cannot be directly reimbursed under the Medicaid Physician Services program. All allied professionals must be under the direct supervision of the physician/NP to whom reimbursement is made. Covered services differ based on the provider providing the service.

Medicaid reimburses for medically necessary services delivered by the following allied professional under the supervision and direction of a physician or NP:

- LMSW — A master's or doctoral degree from a social work program accredited by the Council on Social Work Education and one year of experience working with the population to be served.

All allied professionals are responsible for providing services within their scope of practice as prescribed by South Carolina State Law. Interns are not eligible to provide services to Medicaid beneficiaries and their services are non-billable.

Subsection I: Accessibility of the Teaching Physician

Accessibility of the teaching physician while the resident is providing a service is defined as follows for particular service types.

Ambulatory Services

Accessibility of the teaching physician for supervision of ambulatory services requires the teaching physician to be present in the clinic or office setting while the resident is treating patients. The physician is thus immediately available to review the patient's history, personally examine the patient if necessary, review the records of the encounter and laboratory tests, confirm or revise the diagnoses, and determine the course of treatment.

Inpatient Services

Accessibility of the teaching physician for supervision of non-procedural inpatient services requires that the teaching physician evaluate the patient within 24 hours of admission and on each day thereafter for which services are billed. The teaching physician must review the patient's history, personally examine the patient as needed; review the records of the encounter and laboratory tests, confirm or revise the diagnoses; and determine the course of treatment.

Procedures**Minor Procedures**

For supervision of procedures that take only a few minutes to complete or involve relatively little decision-making once the need for the procedure is determined, accessibility requires that the teaching physician be on the premises and immediately available to provide services during the entire procedure.

All Other Procedures

For supervision of all other procedures, accessibility requires that the teaching physician be physically present during all critical and key portions of the procedure and be immediately available to provide services during the entire procedure.

Special Coverage Groups**Pediatric Anesthesia Services**

Effective June 1, 2008, the South Carolina Department of Health and Human Services (SCDHHS) will expand its coverage of anesthesia services to allow board eligible and/or board certified Pediatric Intensivists to be reimbursed for a limited number of anesthesia Current Procedural Terminology (CPT) codes. Board eligible and/or board certified Pediatric Emergency Medicine Physicians may also be reimbursed for this service if they practice in a facility where a board eligible and/or board certified Pediatric Anesthesiologist and/or a board eligible and/or board certified Pediatric Intensivist is on staff. In addition, the Pediatric Intensivist or Pediatric Emergency Medicine Physician must have a current Pediatric Advanced Life Support (PALS) certification.

The Pediatric Sub-Specialist Program

SCDHHS will reimburse an enhanced rate to certain pediatric sub-specialists that meet the enrollment requirements. Reimbursement for certain E&M codes will be based on a fee schedule not to exceed 116% of Medicare and 97% of Medicare for most other covered CPT codes. Fee schedules are located on the SCDHHS website at: <http://www.scdhhs.gov>.

Pediatric Sub-Specialist Program Participation Requirements

To be eligible for participation in this program, a physician must meet the following criteria:

- Practice within the SCMSA. The South Carolina service area is defined as within 25 miles of the State line.
- At least 85% of total practice, including after-hours patients, is dedicated to children age 18 years or younger.
- Practice in at least one of the following sub-specialties:
 - Adolescent Medicine
 - Allergy
 - Cardiology
 - Cardiothoracic Surgery
 - Child Abuse Pediatrics
 - Critical Care
 - Developmental — Behavioral
 - Emergency Medicine
 - Endocrinology
 - Gastroenterology/Nutrition
 - Genetics
 - Hematology/Oncology
 - Infectious Disease
 - Neonatology
 - Nephrology
 - Neurology
 - Neurological Surgery

- Ophthalmology
 - Orthopedic Surgery
 - Otolaryngology
 - Psychiatry
 - Pulmonology
 - Radiology
 - Rheumatology
 - Surgery
 - Urology
 - Other pediatric subspecialty areas as may be determined by SCDHHS
- Complete and return a copy of the attestation statement found in the Forms section of the Provider Administrative and Billing Manual.

PROVIDER ENROLLMENT AND LICENSING

Clinics and Ancillary Services

Under the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), several specific types of health professionals and facilities are eligible for enrollment in the South Carolina Medicaid program. Their services are compensable only for beneficiaries with special needs, age 21 and under, and are related to an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exam.

These providers include physical therapists, occupational therapists, speech therapists and audiologists. Facilities and private therapists providing rehabilitative services have to meet certain qualifications. Guidelines for these services are outlined in the “Rehabilitative Services Policies and Procedures” Manual available online at: www.scdhhs.gov.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are eligible for participation under South Carolina Medicaid. For information and policy guidelines on these clinics, call the SCDHHS Provider Service Center (PSC) at +1 888 289 0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us>.

EPSDT Provider

Professional practitioners and other providers must be licensed and/or certified by the appropriate standard setting agency to provide services covered by South Carolina Healthy Connections Medicaid program.

- Registered Nurses working in county health department offices must meet the standards for performing EPSDT screenings established by SCDHEC.
- Registered Nurses who perform screenings in schools must have successfully completed the SCDHHS-approved Child Health Maintenance Course. A physician should be available for consultation, if necessary.
- Registered Nurses in physicians' offices or clinics who assist in the performance of EPSDT screenings should do so under the direct supervision of a physician/NP who assumes responsibility for quality of care. They are encouraged to successfully complete the SCDHEC course.
- For application of fluoride varnish, providers must have successfully completed an Oral Health Training Module and keep the Certificate of Completion in their records. SCDHHS recognizes the following Oral Health Trainings for the purpose of Certification:
 - The Bright Futures curriculum and Bright Smiles Oral Health Modules developed by the American Academy of Pediatrics (AAP), accessible at:
<http://www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=584&pagekey=64563&cbreceipt=0>.
 - Smiles for Life excerpts and SCDHHS anticipatory guidance and policy guidelines can be found at: <https://msp.scdhhs.gov/qtip/site-page/fluoride-varnish>.
 - Connecting Smiles modules developed by the SCDHEC in collaboration with SCDHHS are accessible at: <http://www.connectingsmilessc.org/flouride-varnish-training/>.
- Registered Nurses in physicians' offices or clinics who assist in the performance of EPSDT screenings should do so under the direct supervision of a physician/NP who assumes responsibility for quality of care. They are encouraged to successfully complete the SCDHEC course.

Maternal Fetal Medicine Physician Ultrasound Override

Providers must register as a Maternal Fetal Medicine (MFM) specialist in order to receive an authorization number to bypass the limitation on antenatal ultrasounds. The provider's medical license must have the MFM specialty designation to be accepted.

To register as an MFM specialist, providers must send a written request by mail or fax to:

Medicaid Provider Enrollment
PO Box 8809
Columbia, SC 29202-8809
Fax: +1 803 870 9022

Questions should be directed to the PSC at +1 800 289 0709 or providers should submit an online inquiry at <http://www.scdhhs.gov/contact-us>.

Hyperbaric Oxygen (HBO) Therapy Units

Hyperbaric units must be contracted with a hospital even if certified as a freestanding clinic by the Centers for Medicare and Medicaid Services (CMS). This contractual agreement with the hospital involves reimbursement for the technical portion of the therapy only.

Independent Laboratories

Medicaid requires that all enrolled independent laboratories meet Clinical Laboratory Improvement Amendments (CLIA) regulations. CLIA is a regulatory program administered by CMS.

Information concerning CLIA regulations and participation may be obtained through SCDHEC's Division of Certification at: +1 803 545 4205. For Medicaid enrollment information, call or write to:

Medicaid Provider Enrollment
PO Box 8809
Columbia, SC 29202-8809
+ 1 888 289 0709

All independent laboratories must be certified by CMS to perform laboratory tests. CLIA certification must be on file with Medicaid Provider Enrollment. Procedures performed and/or charged when the lab is not certified to perform that particular test will be rejected. Medicaid will not reimburse for services performed prior to certification or prior to enrollment. Independent laboratories that have not enrolled in CLIA also cannot bill Medicaid beneficiaries directly for any services rendered.

Clinical Laboratory Improvement Amendments (CLIA)

Just as Medicaid requires that all enrolled independent laboratories meet CLIA regulations, in accordance with federal regulations (42CFR 493.1809), SCDHHS requires that in order to perform laboratory tests, all laboratory testing sites must have one of the following CLIA certifications:

- Certificate of Registration
- Certificate of Accreditation or Partial Accreditation
- Certificate of Compliance

- Certificate of Waiver
- Physician Performed Microscopy Procedures (PPMP) Certificate

In addition, each site must have an assigned unique 10-digit certification number. Information concerning CLIA regulations and participation guidelines may be obtained from SCDHEC at: +1 803 545 4203 or by writing to:

SCDHEC
Division of Certification
2600 Bull Street
Columbia, SC 29201-1708

Independent Imaging Centers and Mobile Imaging Units

Freestanding imaging centers and mobile imaging units must be enrolled with SCDHHS in order to be reimbursed for services provided. Mobile imaging units must meet SCDHEC certification. Freestanding imaging centers and mobile ultrasound units must be certified by Medicare.

For enrollment information, contact provider enrollment at: + 1 888 289 0709 or visit the website at <http://provider.scdhhs.gov>.

Federally Qualified Health Centers

Provider Enrollment procedures have been implemented as follows:

- A NEW SITE for FQHCs and FQHC Look-A-Likes requires the submission of the (1) Health Resources and Services Administrations (HRSA) Notice of Grant Award and (2) CMS Certification Letter, in addition to the enrollment application.
- ADDING A SITE requires the submission of the HRSA Notice of Grant Award, in addition to the enrollment application.

Note: Information for adding a new site is located in the Terms and Conditions section on the HRSA Notice of Grant Award.

FQHCs must enroll in Medicare; providers are encouraged to concurrently enroll in Medicare and Medicaid.

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COVERED SERVICES AND DEFINITIONS

PRIMARY CARE SERVICES

These services are predominantly billed to Medicaid by PCPs such as family physicians, internists, general practitioners, OB/GYNs and pediatricians. However, the guidelines are written for all physicians rendering services to South Carolina citizens who are Medicaid beneficiaries.

SCDHHS will implement 42 CFR Part 438, 441, and 447 for services provided January 1, 2013 through December 31, 2014. This action implements the Affordable Care Act (ACA) requirement that increases payments to physicians with a specialty designation of family medicine, general internal medicine, pediatric medicine, and related subspecialists for specified primary care services and charges for vaccine administration under the Vaccines for Children (VFC) Program.

To qualify for the enhanced rates, a physician must self-attest to one of the following criteria:

- Board certification in one of the specialty designations by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA).
- Newly enrolled, non-board certified physicians in one of the designated specialties are eligible if they attest to meeting the 60% threshold in the billing of E&M codes in the prior month.

For additional information, providers should contact the PSC at: +1 888 289 0709 or submit an online inquiry at: <http://www.scdhhs.gov/contact-us> for more information.

PHYSICIAN SERVICES

Physician services rendered either in the patient's home, a hospital, a skilled nursing facility (SNF), a physician's office, a clinic, or elsewhere are defined as those services provided by, or under the personal supervision of, an individual licensed under State Law to practice medicine or osteopathy in the state in which he or she is rendering services. When billing for services, the provider of service must be the same as the provider of service noted in the patient's medical record, unless working in an exceptional situation such as supervision, locum tenens, etc. Additionally, Medicaid providers should bill actual charges for their services rather than the anticipated reimbursement. Please refer to the Billing Guidance section of this manual for more detailed Medicaid billing instructions.

OFFICE/OUTPATIENT EXAMS DEFINITIONS

Some phrases commonly used to describe a patient's relationship to a physician or practice group are defined as follows:

- **New Patient** — Medicaid defines a new patient as one visiting the office for the first time. A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. An exception can be justified if all records are lost or destroyed.
- **Established Patient** — An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.

The designation of new or established patient does not preclude the use of a specific level of services. Medicaid will reimburse no more than one visit per day unless medically justified. If a second visit is medically necessary, the second visit must be clearly documented in the patient's chart.

In the instance where a physician is on-call for or covering for another physician, the patient's encounter is classified as it would have been by the physician who is not available. For example, if the patient is an established patient of the physician who is not available, then the covering physician would also report his or her services as an established patient visit.

AMBULATORY CARE VISIT GUIDELINES

Medicaid patients ages 21 and older are allowed 12 ambulatory care visits (ACVs) per year, commencing on July 1st of each year. Beneficiaries under age 21 are exempt from this limitation. Please refer to specific procedure codes information located on the provider portal.

Ambulatory care has been defined as all outpatient (OP) examinations, to include paid claims for the following types of examinations:

- Encounters
- Psychiatric Diagnostic Exam
- Physician Examinations
- Consultations
- Healthy Adult Physical

The following services do not count toward the ACV limit:

- Maternal care, including antepartum and postpartum care.
- Established visits are billed with a primary or secondary pregnancy diagnosis.
- Family Planning visits when billed with the FP modifier (service provided as part of Family Planning Program) or family planning.
- EPSDT screenings.
- Minimal exams performed without a physician's direct involvement for ongoing therapies, blood pressure checks, injections, etc., if billed using the appropriate CPT code.
- Emergency department services.
- Ambulatory visits for beneficiaries who are currently being treated for HIV/AIDS. These recipients will be exempt from the ACV limit even if the services being provided are not related to the actual cancer treatment.

Note: In order to bill for these services, providers must attach the “P4” modifier (a patient with severe systemic disease that is a constant threat to life) to the appropriate E&M code. All claims will be subject to post-payment review by Program Integrity (PI).

- Ambulatory visits for beneficiaries who are currently being treated for cancer. These recipients will be exempt from the ACV limit even if the services being provided are not related to the actual cancer treatment.

Note: In order to bill for these services, providers must attach the “P4” modifier to the appropriate E&M code. All claims will be subject to post-payment review by PI.

- Ambulatory visits medically necessary for patients identified by their physician as having a medical need to exceed the 12 ambulatory visit limits. (Please refer to Medical Necessity guidelines for more detail.)

All covered ancillary services, including other diagnostic lab and x-ray services, are compensable. Surgical procedures, hospital care, and other medically necessary services will be reimbursed by South Carolina Medicaid, regardless of the number of ambulatory visits used by the patient.

Verifying the beneficiary's coverage will reflect the estimated visits remaining at the time of service. The estimated visits only reflect the number of exams paid by Medicaid through the claims processing Medicaid Management Information System (MMIS), and should not be considered a guarantee of payment.

When any services are rendered, providers should always request the beneficiary's Medicaid card and verify coverage. However, possession of the card does not guarantee Medicaid eligibility. Beneficiaries may become ineligible for Medicaid for a given month, only to regain eligibility at a later date. It is possible a beneficiary will present a card during a period of ineligibility. It is very important to verify Medicaid eligibility, coverage and type prior to providing services.

Medicaid eligibility can be verified through the South Carolina Medicaid Web-Based Claims Submission Tool (Web Tool). Please contact the SCDHHS Medicaid PSC at: +1 888 289 0709 for further information.

All examinations rendered after the patient has exhausted his or her ACVs will be rejected. Edit 977 will appear on the rejection notice. The provider is responsible for the exam charge.

EVALUATION AND MANAGEMENT SERVICES

Please refer to the CPT when multiple E&M services are provided on the same date of service (DOS).

Convenient Care Clinics

Effective with dates of services on or after August 1, 2012, the SCDHHS will now allow Convenient Care Clinics (CCCs) to enroll as a provider group for billing purposes. CCCs are located in retail stores, supermarkets and pharmacies and are able to treat uncomplicated minor illnesses and provide preventative healthcare services. They are often referred to as retail clinics, retail-based clinics or walk-in medical clinics.

Episodic Care for adults and children is defined as a pattern of medical and nursing care in which services are provided to a person for a particular problem, without an ongoing relationship being established between the patient and the health care professionals. Examples of Episodic Care include, but are not limited to allergies, bronchitis, ear infections, flu-like symptoms, mononucleosis, motion sickness, blisters, minor burns, minor cuts, sprains and strains. Episodic Care (i.e., sick visits) is covered for all ages, subject to the CCCs Internal policies governing initial age for treatment.

Covered Services

EPSDT for this provider type is limited to children five years and older. For additional program, billing, and reimbursement policy information, please refer to EPSDT Standards in this section.

Immunizations

Vaccinations are covered as indicated under Immunization in this section.

Diabetes Patient Education

Diabetes Management services are medically necessary, comprehensive self-management and counseling services provided by programs enrolled by SCDHHS. Enrolled programs must adhere to

the National Standards for Diabetes Self-Management Education and be recognized by the American Diabetes Association, American Association of Diabetes Educators, Indian Health Services, or be managed by a Certified Diabetes Educator. An eligible beneficiary must have a diabetes diagnosis and be referred by their PCP. For details on this service, please refer to the Diabetes Management Services Provider Manual. Contact the PSC for a list of recognized programs in your area or information on how to become a provider of diabetes education.

Preventative Services

Preventive measures are defined as any routine service exam for adults or children when the procedures are performed in the absence of an illness or complaint(s). A well visit and a sick visit cannot be billed on the same DOS. Generally, the South Carolina Medicaid program requires that a complaint or illness be recorded before a service is compensable. The exceptions to this policy are the EPSDT program and the Healthy Adult Physical Exams program.

Family Planning Services

Family Planning is a limited benefit program available to men and women who meet the appropriate federal poverty level percentage in order to be eligible. This program provides coverage for physical examinations, Family Planning services, Family Planning-related services, and some preventive health screenings. Family Planning promotes the increased use of primary medical care; however, beneficiaries enrolled in this program only receive coverage for a limited set of services. Services provided to men and women enrolled in Family Planning that are not specifically outlined below are the sole responsibility of the beneficiary.

Family Planning services do not require a referral or prior authorization for beneficiaries in Medicaid's managed care programs. All services rendered to dually eligible (Medicare and Medicaid) patients should be filed to Medicare first. Family Planning services that are non-covered services by Medicare are reimbursed by Medicaid. Providers should contact the PSC at: +1 888 289 0709 or submit an online inquiry at: <http://www.scdhhs.gov/contact-us> for billing procedures.

Covered Services

Family Planning services may be prescribed and rendered by physicians, hospitals, clinics, pharmacies, or other Medicaid providers recognized by state and federal laws and enrolled as a Medicaid provider. Services include family planning examinations, counseling services related to pregnancy prevention, contraceptives, laboratory services related to Family Planning, etc., and sterilizations (including vasectomies) accompanied by a completed Sterilization Consent Form (DHHS Form 687) (this form is located in the Forms section of the provider portal).

Long Acting Reversible Contraceptives (LARCs) are covered under both the pharmacy benefit and under the medical benefit using the traditional "buy and bill" method. Any LARC billed to Medicaid through the pharmacy benefit will be shipped directly to the provider's office for insertion. Providers must only bill Medicaid for the insertion of the device when it is purchased through the pharmacy.

All Family Planning services should be billed using the appropriate CPT or Healthcare Common Procedure Coding System (HCPCS) code with an FP modifier and/or an appropriate diagnosis code.

Note: Pregnancy testing (when the test result is negative) is a reimbursable family-planning-related service in two situations:

1. The test is provided at the time family planning services are initiated for an individual.
2. The test is provided after the initiation of family planning services, when the patient may not have used the method properly, or when the patient is having an unusual response to the family planning method.

Examinations/Visits

Four types of visits are covered for beneficiaries enrolled in the Family Planning Program. These visits include biennial (once every two years) physical examinations, annual family planning E&M visits, periodic family planning visits and contraceptive counseling visits.

Initial Family Planning Visit

New patients are not required to have a physical examination during an initial Family Planning visit in order to receive hormonal contraceptives or other family planning procedures as prescribed. A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. This visit must be billed using the appropriate level of CPT E&M codes with an FP modifier.

The initial visit is considered to be the first visit and requires the establishment of the medical record, an establishment of baseline laboratory data, contraceptive and sexually transmitted disease prevention counseling, medically necessary lab tests, and an issuance of supplies or prescriptions. The initial Family Planning Physical Assessment is an integral part of the initial Family Planning visit.

The following services, at a minimum, must be provided during the initial visit:

- Medical history.
- Reproductive life plan.
- Sexual health assessment.
- Height, blood pressure and weight check.
- Documentation of any treatment and/or counseling including administration and/or issuance of contraceptive supplies.

- Counseling and education, as necessary, regarding pregnancy prevention and/or sexually transmitted diseases.

The following services, at a minimum, should be provided during the initial visit:

- Breast exam, >20 years of age for females
- Cervical Cytology, ≥21 years of age for females

Genital exam, to include inspection of skin, hair and perianal region, as well as palpation of inguinal nodes, scrotum and penis for males.

Biennial Physical Examination

The Family Planning Program sponsors adult physical examinations under the following guidelines:

- The examinations are allowed once every two years per beneficiary.
- The examinations are preventive visits.
- There are separate codes for initial patient visits and established patient visits.
- A FP modifier must be used when billing these codes for Family Planning beneficiaries.
- An FQHC would bill each encounter with a FP modifier appended.
- For dates of service on or before September 30, 2015, diagnosis code V70.0 must be used when billing these codes for Family Planning beneficiaries.
- For dates of service on or after October 1, 2015, diagnosis code Z00.00 or Z00.01 must be used when billing these codes for Family Planning beneficiaries.
- The examinations can be performed by a NP, PA or physician.

The adult physical examination for Family Planning beneficiaries is a preventive, comprehensive visit and should contain the following components, at a minimum:

- A past family, social, and surgical history for a new patient or an interval history for an established patient
- Height, weight and body mass index (BMI)
- Blood pressure
- A generalized physical overview of the following organ systems:

- › Abdomen
 - › Heart
 - › Back
 - › Lungs
 - › Breasts (female)
 - › Pelvic (female)
 - › Brief muscular
 - › Peripheral vascular
 - › Brief neurological
 - › Prostate (male)
 - › Brief skeletal
 - › Rectal
 - › Head, Eye, Ear, Nose and Throat (HEENT)
 - › Skin
 - › External genitalia
- Age, gender and risk appropriate preventive health screenings, according to the United States Preventive Services Task Force (USPSTF) Recommendations (Grade A and B only)

For more information on these recommendations, please visit

<https://www.uspreventiveservicestaskforce.org/>.

Screenings

Family Planning covers a limited amount of prevention screening. Please refer to the USPSTF Grade A and B recommendations listed in the chart below.

DESCRIPTION	APPROPRIATE FOR THE FOLLOWING FAMILY PLANNING BENEFICIARIES	ALLOWABLE CODES	REQUIRED MODIFIER	PROVIDER TYPE REQUIREMENTS	NOTES
Age and Risk-Appropriate Screenings for the Following: Alcohol Misuse BRCA Screening Questions Depression Intimate Partner Violence Obesity Tobacco Use Low-Intensity Counseling for the Following: Healthy Diet Skin Cancer Prevention	All adults	96150 96151 96152	FP	NP, PA or Physician	Must occur during physical exam
Cholesterol Abnormalities Screening	Men ages 35+ Men ages 20-35 if at increased risk for coronary heart disease Women ages 20+ if at increased risk for coronary heart disease	80061 82465 83718	FP	NP, PA or Physician	Must occur during physical exam
Diabetes Screening	Asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg	82947 82950 82951 83036	FP	NP, PA or Physician	Must occur during physical exam
Hepatitis C Virus Infection Screening	All adults at high risk for virus infection One-time screening for all adults born between 1945-1965	86803 86804	FP	NP, PA or Physician	Must occur during physical exam
Breast Cancer Screening (Mammography)	Women ages 50-74	77067 77066	FP	Physician Only	Can occur outside physical exam

DESCRIPTION	APPROPRIATE FOR THE FOLLOWING FAMILY PLANNING BENEFICIARIES	ALLOWABLE CODES	REQUIRED MODIFIER	PROVIDER TYPE REQUIREMENTS	NOTES
Abdominal Aortic Aneurysm Screening	Men ages 65-75 who have ever smoked	76706	FP	Physician Only	Can occur outside physical exam
Colorectal Cancer Screening	Men and Women ages 50-75	45331 45378 82270 82274 88305 G0105	FP	Physician Only	Can occur outside physical exam
Lung Cancer Screening for Smokers	Adults ages 55 - 80 who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years	71250	FP	Physician Only	Can occur outside physical exam

The following screenings have age, sex, and/or patient history limitations:

- Breast Cancer Screens (Mammographies) are covered for women ages 50 to 74 years.
- Abdominal Aortic Aneurysm (AAA) screens are limited to men who have had a smoking history and are between the ages of 65 and 75 years.
- Colorectal Cancer screens are covered for both men and women who are between the ages of 50 and 75 years.
- Lung Cancer screens cover both men and women between the ages of 55 and 80 years and meet one or more of the following criteria:
 - Beneficiary is a current smoker
 - Beneficiary had a 30 pack per year history
 - Beneficiary quit smoking within 15 year

Family Planning Counseling must be offered to Family Planning beneficiaries during the physical examination.

Portions of the physical may be omitted if not medically applicable to the beneficiary's condition or if the beneficiary is not cooperative and resists specific system examinations (despite encouragement by the physician, NP or office staff). A note should be written in the record explaining why that part of the exam was omitted.

Note: If a medical condition and/or problem is identified during the physical examination and the provider is unable to offer free or affordable care based on the individual's income, the provider should refer the beneficiary to a provider who can offer services to uninsured individuals (examples include FQHCs, RHCs, free clinics, etc.). Please refer to "Referral Instructions for Family Planning" in this section for important information about billing for beneficiary referrals.

The following lab procedures are included in the reimbursement for the physical examination:

- Hemocult
- Urinalysis
- Blood Sugar
- Hemoglobin

Note: College physicals, direct observed therapy (DOT) physicals, and administrative physicals are not covered.

Annual Family Planning Evaluation/Management Visits

The Family Planning Program sponsors annual Family Planning Evaluation/Management visits. The annual visit is the re-evaluation of an established patient requiring an update to the medical record, interim history, physical examination, appropriate diagnostic laboratory tests and/or procedures, Family Planning Counseling, and adjustment of contraceptive management as indicated. This visit should be billed using the appropriate level of CPT E&M with an FP modifier.

The following services, at a minimum, must be provided during the annual visit:

- Medical history
- Sexual health assessment
- Weight
- Blood pressure check
- Symptom appraisal, as needed
- Documentation of any treatment and/or counseling including administration and/or issuance of contraceptive supplies
- Counseling and education, as necessary, regarding pregnancy prevention and/or sexually transmitted diseases
- Breast exam, annually if >19 years of age; then every three years if 20–39 years of age
- Cervical Cytology:
 - Every three years if ≥ 21 years of age
 - Every five years if ≥ 30 years of age
- Genital exam, to include inspection of skin, hair and perianal region, as well as, palpation of inguinal nodes, scrotum and penis
- Laboratory tests
- Issuance of birth control supplies or prescription

Periodic Revisit

The Family Planning Program sponsors periodic revisits for beneficiaries, as needed. The periodic revisit is a follow-up of an established patient with a new or an existing family planning condition. These visits are available for multiple reasons such as change in contraceptive method due to problems with that particular method (e.g., breakthrough bleeding or the need for additional guidance) or issuance of birth control supplies. This visit should be billed using the appropriate level of E&M with an FP modifier.

For E&M, the following services, at a minimum, must be provided during the revisit:

- Weight and blood pressure check
- Interim history
- Documentation of any treatment and/or counseling including administration and/or issuance of contraceptive supplies

The following services, at a minimum, should be provided during the periodic visit:

- Symptom appraisal, as needed
- Laboratory tests
- Issuance of birth control supplies or prescription

Family Planning Counseling Visits

The Family Planning Program sponsors Family Planning Counseling Visits for beneficiaries. The Family Planning Counseling/Education visit is a separate and distinct service (Preventative Medicine Counseling and/or Risk Factor Reduction Intervention) with an FP modifier. Family Planning Counseling/Education is a face-to-face interaction to enhance a beneficiary's comprehension of, or compliance with, his or her family planning method of choice. These services are for the expressed purpose of providing education/counseling above and beyond the routine contraceptive counseling that are included in the clinic/office visits.

Note: This service may not be billed on the same day as another visit.

Covered Contraceptive Supplies and Services

The Family Planning Program provides coverage for contraceptive supplies (for example, birth control pills or male condoms) and contraceptive services such as an injection, intrauterine device (IUD), Essure®, or sterilization. When billing for contraceptive services and supplies, all claims must bill using a relevant Family Planning diagnosis code.

Long Acting Reversible Contraceptives (LARCs)

LARCs are covered under both the pharmacy benefit and under the medical benefit using the traditional “buy and bill” method. Any LARC billed to Medicaid through the pharmacy benefit will be shipped directly to the provider’s office for insertion. Providers must only bill Medicaid for the insertion of the device when it is purchased through the pharmacy.

Note: Pregnancy testing (when the test result is negative) is a reimbursable Family Planning service in two situations:

1. The test is provided at the time family planning services are initiated for an individual.
2. The test is provided after the initiation of family planning services, when the patient may not have used the method properly, or when the patient is having an unusual response to the family planning method.

Covered Screenings and Testing

The Family Planning Program provides coverage for sexually transmitted infections (STI) screenings including: syphilis, chlamydia, gonorrhea, herpes, candidiasis, trichomoniasis and HIV, when performed at the time of the physical examination, initial or annual family planning visits. All diagnostic tests will require the FP modifier to be appended to the CPT/HCPCS codes. All claims must contain a relevant Family Planning diagnosis code.

Covered Medication

If, during a physical examination or annual family planning E&M visit, any of six specific STIs are identified, antibiotic treatment will be allowed under the Family Planning Program. The six STIs are: syphilis, chlamydia, gonorrhea, herpes, candidiasis and trichomoniasis. Beneficiaries are responsible for any copayments. STI testing and treatment are only covered during the beneficiaries’ physical examination or annual family planning visit.

Breast and Cervical Cancer Early Detection Program (Best Chance Network)

The South Carolina Breast and Cervical Cancer Early Detection Program (Best Chance Network) provides coverage for women under the age of 65 who have been diagnosed and found to be in need of treatment for either breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia). For further information, providers or beneficiaries may call toll free +1 888 549 0820.

Department of Health and Environmental Control

SCDHEC provides outreach and direct FP services as part of the waiver and will assist women in finding a PCP or clinic to provide Family Planning services. Participants in the FP program can call toll free +1 855 472 3432 for more information about covered services and health department locations. Also, SCDHEC contracts with private physicians who will offer FP services to participants.

Tobacco Cessation

Tobacco use is the leading cause of preventable disease and premature death in South Carolina. SCDHHS provides comprehensive coverage for tobacco cessation treatment through pharmacotherapy and counseling for all full-benefit Medicaid beneficiaries. SCDHHS also partners with SCDHEC to communicate about programs available to assist Medicaid beneficiaries with quitting tobacco use.

Providers are encouraged to screen beneficiaries for tobacco use during medical encounters and document nicotine dependence using the appropriate diagnosis codes.

Medication

SCDHHS covers prescriptions for the following tobacco cessation and nicotine replacement therapy (NRT) products:

- Bupropion sustained release (SR) products for tobacco use (Zyban)
- Varenicline (Chantix) tablets
- Nicotine gum
- Nicotine lozenge
- Nicotine nasal spray
- Nicotine inhaler
- Nicotine patch

Tobacco cessation products are exempt from the adult monthly prescription limit, prior authorization, and copayment requirements. There is no limit to the number of quit attempts in a calendar year. The following medically appropriate combination therapies are also covered:

- Long-term nicotine patch + other NRT product (gum or spray)
- Nicotine patch + nicotine inhaler
- Nicotine patch + Bupropion SR

General edits on day supply are based on product dosing in manufacturer package inserts. Prescribers are encouraged to reference the AAFP Pharmacologic Product Guide for Food and Drug Administration (FDA)-approved medications for smoking cessation for more information on product guidelines.

As with all other pharmaceuticals, SCDHHS reimburses only rebated products (brand or generic) for fee-for-service (FFS) beneficiaries. A beneficiary must provide a prescription to receive any medication, including over-the-counter (OTC) products. A dual-eligible member can receive OTC products through Medicaid coverage, but the individual's Medicare Part D prescription drug plan must cover prescriptions for legend (non-OTC) tobacco cessation products.

For further questions about this benefit, prescribers should contact the pharmacy benefit administrator. For contact information refer to the Provider Administrative and Billing Manual.

Counseling

Tobacco cessation counseling in individual and group settings are covered when billed with the appropriate code. Reimbursement for counseling is limited to four sessions per quit attempt for up to two quit attempts annually. Tobacco cessation counseling may be billed on the same day as an office visit using an appropriate modifier.

SCDHHS policy requires that all tobacco cessation treatment must be ordered by a qualified practitioner defined as a physician, NP, CNM or PA. Medical documentation including time spent counseling the patient, treatment plan, and pharmacotherapy records must be maintained in the patient record.

South Carolina Tobacco Quitline

One-on-one telephone counseling with web-based support are available to all South Carolinians without charge through the South Carolina Tobacco Quitline. Participants in the Quitline program are connected with a personal Quit Coach, who helps the participant develop a quit plan and uses cognitive behavioral coaching and motivational interviewing techniques to support the quit process. This evidence-based program has been clinically proven to help participants quit tobacco use, and tailored programs are available for Hispanic, Native American, pregnant and youth callers, and smokeless tobacco users, as well as participants who have chronic medical and mental health conditions.

SCDHHS strongly encourages prescribers and pharmacists to refer patients to the South Carolina Tobacco Quitline at: +1 800 QUIT NOW. Services are available 24 hours a day, seven days a week. Additional information is available at:

<http://www.scdhec.gov/Health/TobaccoCessation/HelpYourPatientsQuit/>

Telemedicine

Telemedicine is the use of medical information about a patient that is exchanged from one site to another via electronic communications to provide medical care to a patient in circumstances in which face-to-face contact is not necessary. In this instance, a physician or other qualified medical professional has determined that medical care can be provided via electronic communication with no loss in the quality or efficacy of the care. Electronic communication means the use of interactive telecommunication equipment that typically includes audio and video equipment permitting two-way,

real-time interactive communication between the patient and the physician or practitioner at the referring site.

Telemedicine includes consultation, diagnostic and treatment services. Telemedicine as a service delivery option, in some cases, can provide beneficiaries with increased access to specialists, better continuity of care, and eliminate the hardship of traveling extended distances.

Telemedicine services are not an expansion of Medicaid-covered services but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective through medical assessment or problems in beneficiaries' understanding of telemedicine, hands-on or direct face-to-face care must be provided to the beneficiary instead. Quality of health care must be maintained regardless of the mode of delivery.

Consultant Sites

A consultant site means the site at which the specialty physician or practitioner providing the medical care is located at the time the service is provided via telemedicine. The health professional providing the medical care must be currently and appropriately licensed in South Carolina and located within the South Carolina Medical Service Area (SCMSA), which is defined as the State of South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina State border.

Referring Sites

A referring site is the location of an eligible Medicaid beneficiary at the time the service being furnished via a telecommunication system occurs. Medicaid beneficiaries are eligible for telemedicine services only if they are presented from a referring site located in the SCMSA. Referring site presenters may be required to facilitate the delivery of this service. Referring site presenters should be a provider knowledgeable in how the equipment works and can provide the clinical support if needed during a session.

Covered referring sites are:

- The office of a physician or practitioner
- Hospital (inpatient and OP)
- RHCs
- FQHCs
- Community Mental Health Centers
- Public Schools

- Act 301 Behavioral Health Centers

Telemedicine Providers

Providers who meet the Medicaid credentialing requirements and are currently enrolled with the South Carolina Medicaid program are eligible to bill for telemedicine and telepsychiatry when the service is within the scope of their practice.

The referring provider is the provider who has evaluated the beneficiary, determined the need for a consultation, and has arranged the services of the consulting provider for the purpose of consultation, diagnosis and/or treatment.

The consulting provider is the provider who evaluates the beneficiary via telemedicine mode of delivery upon the recommendation of the referring provider. Practitioners at the distant site who may furnish and receive payment of covered telemedicine services are:

- Physicians
- NPs
- PAs

Covered Services

Services that are eligible for reimbursement include consultation, office visits, individual psychotherapy, pharmacologic management, and psychiatric diagnostic interview examinations and testing, delivered via a telecommunication system. A licensed physician and/or NP are the only providers of telepsychiatry services. As a condition of reimbursement, an audio and video telecommunication system that is Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant must be used that permits interactive communication between the physician or practitioner at the consultant site and the beneficiary at the referring site.

Office and OP visits that are conducted via telemedicine are counted towards the applicable benefit limits for these services.

Medicaid covers telemedicine when the service is medically necessary and under the following circumstance:

- The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's need, and
- The medical care can be safely furnished, and no equally effective and more conservative or less costly treatment is available Statewide.

The list of Medicaid telemedicine services includes:

- Office or other OP visits
- Inpatient consultation
- Individual psychotherapy
- Psychiatric diagnostic interview examination
- Neurobehavioral status examination
- Electrocardiogram (EKG) interpretation and report only
- Echocardiography

Coverage Guidelines

The following conditions apply to all services rendered via telemedicine.

- The beneficiary must be present and participating in the telemedicine visit.
- The referring provider must provide pertinent medical information and/or records to the consulting provider via a secure transmission.
- Interactive audio and video telecommunication must be used; permitting encrypted communication between the distant site physician or practitioner and the Medicaid beneficiary. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telemedicine information transmitted.
- The telemedicine equipment and transmission speed and image resolution must be technically sufficient to support the service billed. Staff involved in the telemedicine visit must be trained in the use of the telemedicine equipment and competent in its operation.
- An appropriate certified or licensed health care professional at the referring site is required to present (patient site presenter) the beneficiary to the physician or practitioner at the consulting site and remain available as clinically appropriate.
- If the beneficiary is a minor child, a parent and/or guardian must present the minor child for telemedicine service unless otherwise exempted by State or Federal law. The parent and/or guardian need not attend the telemedicine session unless attendance is therapeutically appropriate.
- The beneficiary retains the right to withdraw at any time.

- All telemedicine activities must comply with the requirements of HIPAA: Standards for Privacy of individually identifiable health information and all other applicable State and Federal Laws and regulations.
- The beneficiary has access to all transmitted medical information, with the exception of live interactive video, as there is often no stored data in such encounters.
- There will be no dissemination of any beneficiary's images or information to other entities without written consent from the beneficiary.
- The provider at the distant site must obtain prior approval for service when services require prior approval, based on service type or diagnosis.

Unusual Travel

This service is compensable only when a patient must be transported to a medical facility and is accompanied by a physician because there is no other recourse available based on the necessary medical skills and expertise required for the patient's condition. Documentation must be submitted with the claim. Coverage and reimbursement will be determined on a claim-by-claim basis.

Unlisted Services or Procedures

A service or procedure may be provided that is not listed in the CPT. When reporting such a service, the appropriate "unlisted" procedure code may be used to indicate the service, identifying it by special report.

Appropriate records to justify the use of the unlisted code, the complexity of the service, and the charge must accompany the unlisted procedures. The reimbursement will be directly related to the support documentation submitted with the claim. To ensure proper interpretation and payment, a complete description of the performed service is required.

Procedures that are considered an integral part of an examination should not be charged separately (i.e., simple vision test, blood pressure check, ophthalmoscopy, otoscopy). Charges for these services in addition to an E&M visit will be denied.

Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)

P/RSPCE are provided to support primary medical care in patients who exhibit risk factors that directly impact their medical status. These services are designed to help the physician maximize the patient's treatment benefits and outcomes by supplementing routine medical care.

These services can be provided by public health nurses, social workers, dietitians, health educators, home economists, and public health assistants who have special training and experience in working in the home or other community setting to assist the client in meeting mutually developed health care objectives.

Following are examples of P/RSPCE:

- Comprehensive assessments/evaluations of a client's medical, nutritional or psychosocial needs by health professionals.
- Home or community follow-up as requested by a PCP to monitor the medical plan of care, reinforce the treatment regime, counsel, provide anticipatory guidance, and support the client's medical needs. Nurses can apply the nursing process with the overall aim of optimizing the health outcomes of the client.
- Social work assessment, counseling or anticipatory guidance relative to the medical plan of care
- Medical nutrition therapy for clients with chronic disease, growth problems, medically diagnosed anemias, elevated blood lead or other nutritional disorders.
- Coordination of medical services for clients with multiple providers and/or complex needs.

Counseling interventions address the client's attitude, knowledge base, beliefs, behaviors and values relative to the medical condition. Individual and group interventions are tailored to meet the patient's needs and include specific targeted actions that are more than simple didactic presentations of information. These actions are intended to be collaborations between the P/RSPCE, the PCP and the patient.

Contact the PSC for more details on P/RSPCE services.

Missed Appointments

Medicaid beneficiaries cannot be charged for missed appointments. A missed appointment is not a distinct reimbursable Medicaid service, but a part of provider's overall costs of doing business. The Medicaid rate covers the cost of doing business, and providers may not impose separate charges on beneficiaries.

Home Health Services — Physician Requirements

Home health services are provided only by home health agencies that are certified by SCDHEC and have contracted with SCDHHS. Coverage is dependent upon a physician's orders and payable only to a contracted home health agency.

Plan of Care

Covered home health services must be ordered by the beneficiary's attending physician as part of a written plan of care, consistent with the functions the practitioner is legally authorized to perform. The plan of care should specify the treatment, services, items or personnel needed by the patient and the expected outcome. The care must be appropriate to the home setting and to the patient's needs. For additional information, providers should contact the PSC at: +1 888 289 0709 or submit an online inquiry at: <http://www.scdhhs.gov/contact-us>.

Long-Term Living Program

The Community Long-Term Care (CLTC) Program is designed to serve Medicaid-eligible aged and disabled adults who require long-term care. Careful assessment, service planning, and counseling allow each client to receive care in his or her own home, thus avoiding premature and costly nursing home admission.

For additional information, providers should contact the PSC or submit an online inquiry.

Nursing Home/Rest Home Facility Services

Services provided by a physician for a patient residing in a nursing home or long-term care facility must be medically necessary, requested by the patient or responsible party, or performed to meet the requirements of continued long-term care.

Services such as physical therapy (PT), occupational therapy (OT), recreational therapy, dietary consultation, social services, and nursing care are reimbursable only through the nursing home facility charges, according to the per diem rate.

If nursing home placement is not available, please refer to “Administrative Days” under “Inpatient and Outpatient Hospital Services” in this section.

The attending physician must submit signed and dated certification by the 60th day of the patient’s stay at the SNF in order for the patient to remain certified.

Injections**Coverage Guidelines**

Injectable drugs are covered if the following criteria are met:

- They are of the type that cannot be self-administered. The usual method of administration and the form of the drug given to the patient are two factors in determining whether a drug should be considered self-administered. If a form of the drug given to the patient is usually self-injected (e.g., insulin), the drug is excluded from coverage unless administered to the patient in an emergency situation (e.g., diabetic coma).
- The medical record must substantiate medical necessity. When acceptable oral and parenteral preparations exist for necessary treatment, the oral preparation should be the route of administration. If parenteral administration is necessary, the record should document the reason for choosing this route.
- Use of a drug or biological must be safe and effective, and otherwise reasonable and necessary. Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling. Occasionally, FDA-approved drugs are used for indications other than those specified on the labeling.

Provided the FDA has not specified such use as non-approved, coverage is determined considering the generally accepted medical practice in the community.

- Drugs and biologicals that have not received final marketing approval by the FDA are not covered unless CMS advises otherwise.
- The injection must be furnished and administered by a physician, or by auxiliary personnel employed by the physician and under his or her personal supervision.
- When billing for a drug administered in the office, the physician must bill an injection code. A prescription cannot be filled by a pharmacist and then returned to a physician's office for administration.

Orphan Drugs

An orphan drug is a drug or biological product used for the treatment or prevention of a rare disease or condition. Prior approval is required for orphan drugs that are not listed on the injection code list.

Unlisted Injections

If an injection is not listed, the appropriate J code should be used. A description of the drug, the National Drug Code (NDC) number, and the dosage, along with the office record, flow record (if possible), and an invoice indicating the cost of the drug, must all be attached to the claim to be considered for payment. Claims containing this code without the required documentation will be rejected. Additional documentation may be required if the unlisted injection is being submitted for reimbursement for the first time. When a claim is rejected, providers must submit a new claim and attach the required documentation for medical review.

When billing multiple unlisted injection codes on the same claim, the documentation must identify the specific unlisted code that is to be considered for reimbursement.

The appropriate procedure code is billed per injection for administration.

Botox®, Dysport®, Myobloc®, and Xeomin®

Botox®, Injection, OnabotulinumtoxinA

Botox® is FDA-approved for strabismus, blepharospasm, severe primary axillary hyperhidrosis, upper limb spasticity in adults, cervical dystonia in adults, and for the prophylaxis of headaches in adult patients with chronic headache and chronic migraine prophylaxis (≥15 days per month with headache lasting four hours a day or longer). In addition, Botox® is FDA-approved to treat urinary incontinence due to detrusor over activity associated with a neurologic condition [e.g., spinal cord injury, multiple sclerosis (MS)] in adults who have an inadequate response to or are intolerant of an anticholinergic medication.

- Dysport®
- Dysport® is FDA-approved for cervical dystonia in adults
- Myobloc® injection, rimabotulinumtoxinb
- Myobloc® is FDA-approved for cervical dystonia in adults
- Xeomin® injection, incobotulinumtoxina
- Xeomin® is FDA-approved for cervical dystonia in adults and for blepharospasm in adults previously treated with onabotulinumtoxinA (Botox®)

The botulinum toxin products listed on the left share certain properties and some FDA approved indications. However, these agents are not identical. They have differing therapeutic and adverse even profiles. Botulinum toxin products are not directly interchangeable with one another.

SCDHHS requires support documentation to be submitted with claims filed for Botox®, Dysport®, Xeomin® or Myobloc®. Medicaid will pay claims for Botox®, Dysport®, Xeomin® or Myobloc® only when administered for FDA-approved indications. Therefore, medical records submitted with the claim must:

- Include the beneficiary's age
- Clearly delineate the symptom or particular circumstance that necessitates the administration of Botox®, Dysport®, Xeomin® or Myobloc®

Claims will reject if information is omitted or if it cannot be determined that the product was given for an FDA-approved indication.

All Botulinum toxin products must be preauthorized by Magellan Rx Management except for those being administered to patients who are dually eligible for Medicare and Medicaid (please refer to Utilization Review Services in this section for more information) Magellan Rx Management will pre-authorize all Botulinum Toxin — Type A for Botox® and Type B (Myobloc®) when administered for FDA-approved indications.

Xolair® (Omalizumab)

Xolair® is FDA-approved for patients 12 years of age or older under some circumstances (see below for more detail). Physician CMS-1500 claims should be billed using the appropriate J code and must include the prior authorization number. Claims submitted without prior authorization number will be rejected. Providers should submit prior authorization requests to Magellan Rx Management at: <http://ih.magellanrx.com> or by calling +1 800 424 8219.

SCDHHS requires prior approval for Xolair® (Omalizumab), 150 mg powder/vial. Prior authorization requests should be telephoned or faxed, toll-free, to the pharmacy benefit administrator. For contact information, refer to the Provider Administrative and Billing Manual.

Authorizations will be based on the following criteria:

FDA-Labeled Indications:

- Approved for treatment of patients 12 years of age or older with moderate persistent or severe persistent asthma for at least one year, who have had positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids.
- Symptoms not adequately controlled with the following three treatments:
 - Patient must have tried or have a contraindication to inhaled corticosteroids.
 - Patient should have tried or have a contraindication to long acting Beta 2 agonists (Reference: National Heart, Lung, and Blood Institute (NHLBI) guidelines).
 - Patient should have tried or have a contraindication to a leukotriene receptor antagonist.

Length of Prior Authorization:

- Six months
- Provider must verify clinical improvement at each subsequent renewal, if approved.

The Physician Requesting the Prior Approval Must be one of the Following:

- Allergist/Immunologist
- Pulmonologist

Required Labs:

- History of positive skin test or radioallergosorbent (RAST) test to a perennial aeroallergen.
- Pretreatment serum IgE level should be 30 to 700 IU/ml.
- Weight and height

Preventive Care Services

Preventive measures are defined as any routine service exam for adults or children when the procedures are performed in the absence of an illness or complaint(s). Generally, the South Carolina Medicaid program requires that a complaint or illness be recorded before a service is compensable. The exceptions to this policy are listed below:

Cancer Screening Services

For dates of service on or before September 30, 2015, International Classification of Diseases (ICD)-9-CM codes for cancer screening services are located on the Physicians Services Provider Manual webpage.

For dates of service on or after October 1, 2015, the cancer screening services in the following table are covered. Please refer to the current edition of the ICD-10 for the most appropriate diagnosis code. If a more appropriate code is not available, use diagnosis code Z00.8.

SERVICE	PROCEDURE CODE	FREQUENCY LIMITATIONS	COMMENTS
Mammography	77067	Baseline (ages 35-39*). 1 per year (ages 50 and over).	Must be referred by a physician.
Hemocult Test	One of the following: 82270, 82271 or 82272	1 per year age 50 and up for low-risk clients Age 40 and up for high-risk clients***	The hemocult code includes both the collection of the stool and interpretation of the test.
Sigmoidoscopy	G0104	1 per 5 years age 50 and up for low-risk clients. Age 40 and up for high-risk clients.	
Screening Colonoscopy	G0121 G0105	1 per 10 years age 50 and up for low-risk clients. Age 40 and up for high-risk clients.	

* The age limits on the cancer screening services are the recommended ages to begin screening services. If medically indicated, screening services are reimbursable to younger beneficiaries provided the medical documentation supports the screening service.

** Low-risk clients — no risk factors known.

*** High-risk clients — personal history of polyps, ulcerative colitis, or colorectal cancer; family history of breast or gynecological cancer.

FFS Adult Nutritional Counseling Program

This policy currently targets those obese individuals who do not meet the criteria for gastric bypass surgery or related services. Obesity is defined for this program as anyone the age of 21 or older with a BMI of 30 or greater.

Currently, this program will exclude the following categories of beneficiaries:

- Pregnant women
- Patients, for whom medication use has significantly contributed to the beneficiary's obesity as determined by the treating physician, are not eligible to participate in the obesity program. Examples of medications that may cause weight gain are:
 - Atypical antipsychotics (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone)
 - Long-term use of oral corticosteroids (prednisone, prednisolone)
 - Certain anticonvulsant medications (valproic acid, carbamazepine)
 - Tricyclic antidepressants (amitriptyline)
- Beneficiaries who have had or are scheduled to have bariatric surgery/gastric banding/gastric sleeve.
- Beneficiaries actively being treated with gastric bypass surgery/vertical-banded gastroplasty/sleeve gastrectomy.

Note: for Healthy Connections Medicaid members also receiving Medicare benefits, SCDHHS will only pay secondary payments to Medicare.

Medicaid obesity counseling intervention consists of three factors:

- Screening for obesity in adults using measurement of BMI. The BMI is calculated by dividing the patient's weight in kilograms by the square of height in meters.
- Dietary (nutritional) assessment.
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions related to diet and exercise.

Provider Services

A "provider" is defined as a physician, PA or NP meeting the licensure and educational requirements within the State of South Carolina.

During the patient's routine physical exam or office visit, the provider will assess the patient's need for an obesity intervention program.

All obesity visits must include the following components listed below:

- **Assess:** Ask about and assess behavioral health risk and factors affecting behavioral change goals/methods.
- **Advise:** Give clear, specific and personalized behavioral advice, including information about personal health, harms and benefits.
- **Agree:** Collaborate with the patient to select appropriate treatment goals and methods based on the patient's interest and willingness to change behavioral patterns and habits.
- **Assist:** Use behavioral change techniques (self-help and/or counseling) to aid the patient in achieving agreed upon goals by acquiring the skills, confidence, and social, environmental supports for behavioral change, supplemented with adjunctive medical treatments when appropriate.
- **Arrange:** Schedule follow-up contacts to provide ongoing assistance and/or support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

The provider must also emphasize the importance of exercise, developing a realistic exercise plan with goals. The obesity intervention plan must be documented in the patient's medical health record.

The provider will arrange for an individual nutritional assessment to be provided by a licensed and Medicaid-enrolled dietitian.

A follow-up exam must be completed by the provider to evaluate the progress the patient has made, reviewing compliance with the exercise and nutritional plan of the patient. Documentation of each service must include the patient's BMI, progress toward weight management goals, activities and compliance with the treatment plan. The provider must record the patient's BMI in the chart. Providers may bill for all medically necessary diagnostic testing.

Dietitian Services

The dietitian is responsible for reviewing the patient's habits, providing dietary education, reinforcing the importance of exercise, developing a nutritional plan and establishing goals. The dietitian must document the patient's progress, activities, and compliance with the nutritional and exercise plan. A written progress report must be submitted within 48 hours of the nutritional counseling visit to the ordering provider each time the patient is seen individually or in a group/class setting. The dietitian must maintain complete medical records of the patient's nutritional and exercise plan, and his or her compliance with the obesity treatment regimen.

Additional Services

If the provider (or dietitian) has completed a series of six visits and the patient has been compliant with the obesity treatment plan and the provider (or dietitian) has determined that the patient would benefit from additional provider visits and nutritional counseling, the provider must submit documentation of medical necessity to:

SCDHHS

Attention: Medical Director

PO Box 8206

Columbia, SC 29202

In order to receive additional visits not to exceed six additional provider visits and six additional nutritional counseling sessions within a 12-month period, the following documentation must be submitted to SCDHHS by the physician, NP or PA only:

- A letter of medical necessity
- Patient notes
- BMI start and end
- A1C
- Dietitian reports
- Exercise plan and notes on adherence

Additional Resources

For additional resources, providers should visit the SCDHEC's Obesity Resources for Community Partners webpage at: <https://www.scdhec.gov/health/nutrition-obesity-physical-health/resources-community-partners>.

Some examples of current programs include:

- Statewide Obesity Action Plan
- Community Transformation Grant
- Worksite Wellness
- FitnessGram
- ABC Grow Healthy

- Farm to School
- SNAP Education (SNAP-Ed)

Adult Physical Exams

This exam may also be offered to patients with Medicare and Medicaid. The physical exam is expected to include the following:

- A past history for a new patient or an interval history on an established patient.
- A generalized physical overview of the following organ systems:
 - Abdomen
 - Back
 - Breasts (female)
 - Brief Muscular
 - Brief Neurological
 - Brief Skeletal
 - External genitalia
 - Heart
 - HEENT
 - Lungs
 - Pelvic (Female)*
 - Peripheral Vascular
 - Prostate (Male)
 - Rectal
 - Skin
- Family Planning Counseling must be offered if the patient is female within childbearing years or men. (An additional Family Planning code may be billed for this service when provided. Please refer to Obstetrics and Gynecology in this section of the manual for the description of codes.)

- The following lab procedures are included in the reimbursement for the physical:
 - Blood Sugar
 - Hemocult
 - Hemoglobin
 - Urinalysis

Any other lab procedures, x-rays, etc., may be billed separately. Portions of the physical may be omitted if not medically applicable to the patient's condition or if the patient is not cooperative and resists specific system examinations (despite encouragement by the physician and office staff). A note should be written in the record explaining why that part of the exam was omitted.

Diabetes Patient Education

Diabetes Management services are medically necessary, comprehensive self-management and counseling services provided by programs enrolled by SCDHHS. Enrolled programs must adhere to the National Standards for Diabetes Self-Management Education and be recognized by the American Diabetes Association, American Association of Diabetes Educators, Indian Health Services, or be managed by a Certified Diabetes Educator. An eligible beneficiary must have a diabetes diagnosis and be referred by their PCP.

For details on this service, please refer to the Enhanced Services Provider Manual. Contact the PSC for a list of recognized programs in your area or information on how to become a provider of diabetes education.

Immunizations

Immunizations for Children

The VFC Program is a federally funded program created by the Omnibus Budget Reconciliation Act of 1993 that provides vaccines at no cost to children who qualify. Children who are eligible for VFC are entitled to receive pediatric vaccines that are recommended by the Advisory Committee on Immunization Practices (ACIP). In South Carolina, the VFC Program is managed by the SCDHEC.

Medicaid providers may obtain free vaccines from the SCDHEC through the VFC Program. Vaccines are delivered free of charge to providers enrolled in the program. For additional information on the VFC Program or to enroll as a provider in the program, you may contact SCDHEC at: +1 803 898 0460 (local) or +1 800 27 SHOTS (outside the Columbia area). You may also visit the SCDHEC website at: <http://www.scdhec.gov/Health/Vaccinations/>.

Note: The Rabies vaccine is non-covered through the VFC for children as it is not considered routine. However, the Rabies vaccine is covered by Medicaid for children. Providers may bill the appropriate administration and vaccine code to receive reimbursement from Medicaid.

Respiratory Syncytial Virus (RSV) Immune Globulin (Synagis®)

Medicaid covers the administration of Synagis® in accordance with the recommendation published by the AAP. The AAP guidelines are available at: <http://www.aap.org>.

Immunizations for Adults

The following vaccines are covered in accordance with the Centers for Disease Control and Prevention (CDC) ACIP for adult beneficiaries 19 years of age and older:

- 13-valent pneumococcal conjugate (PCV13)
- 23-valent pneumococcal conjugate (PPSV23)
- Haemophilus influenza type b conjugate vaccine (Hib)
- Hepatitis A (HepA)
- Hepatitis B (HepB)
- Influenza
- Measles, mumps, and rubella (MMR)
- Measles, mumps, rubella, and varicella (MMRV)
- Rabies
- Serogroups A, C, W, and Y meningococcal conjugate or polysaccharide vaccine (MenACWY or MPSV4)
- Serogroup B meningococcal (MenB)
- Tetanus and diphtheria toxoids (Td)
- Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap)
- Varicella (VAR)

For details on specific products covered, please refer to the CDC website at:
<https://www.cdc.gov/vaccines/index.html>.

Pediatrics and Neonatology

All procedures, with the following exceptions, must be submitted under the child's own Medicaid number regardless of the child's age.

Newborn Care for the Sick Newborn

A sick child is defined as a newborn not considered a well-baby, but not sick enough to be considered a neonate or critically ill.

High Risk Channeling Project (HRCP) Neonatal Risk Screening

Please refer to Best Practice Guidelines for Perinatal Care (Replaces High Risk Channeling Project — HRCP) under “Obstetrics and Gynecology” in this section.

Postpartum Infant Home Visit

The postpartum infant home visit is designed to assess the environmental, social, and medical needs of the infant and mother. All Medicaid-sponsored postpartum mothers and newborns are eligible for this visit, within six weeks of delivery. Providers must be enrolled as a Postpartum Infant Home visit provider to perform this service. The Division of Care Management should be contacted for enrollment at: +1 803 898 4614. For further details on this service, providers should refer to the Enhanced Services Provider Manual.

Sudden Infant Death Syndrome (SIDS)

SIDS is defined as the unexpected and sudden death of an apparently normal and healthy infant that occurs during sleep and with no physical or autopsy evidence of disease.

Sick Child Care

Physicians are reimbursed for all services provided to Medicaid-eligible children as long as the services are medically necessary and a diagnostic reason for the service is documented in the physician's records. Children (age birth through the end of the month of 21st birthday) are eligible for unlimited office visits as long as the previously mentioned criteria are met.

Neonatology**Pre-Discharge Home Visit**

The pre-discharge home visit is designed to assess the condition of the home of an infant who is, or has been a patient, in a neonatal intensive care unit (NICU), or who has had a significant medical problem. The goal is to ensure a safe environment, conducive to maintaining the health status of the infant, after discharge from the hospital.

The visit must be made in response to a referral by a physician directly involved in the care of the infant while hospitalized (unless the infant is a member of a Managed Care Organization [MCO]). This also applies to infants who have been transported from the Level III hospital back to their county of residence.

Forensic Medical Evaluations

Effective February 1, 2009, SCDHHS will reimburse Forensic Medical Evaluation services for beneficiaries up to age 21. The purpose of the forensic evaluation is to:

- Determine if a child has been abused, and to identify possible perpetrators.
- Gather forensically sound facts necessary to assist law enforcement officials and protect the child.
- Allow the child to disclose information in a non-threatening environment and assess the extent and nature of the alleged abuse.
- Evaluate the child's social and behavioral functioning in order to make treatment recommendations, and to establish a foundation for effective treatment if needed.

This service will be covered when billed in association with a South Carolina State Office of Victim Assistance (SOVA) service that meets the threshold of State Law Section 16-3-1350 that governs criminal sexual conduct or child sexual abuse. Coverage will also include those events that meet the reporting requirements of the South Carolina Department of Social Services (DSS) Child Protective Services State Law Section 63-7-310 identifying and reporting child abuse and neglect. An event is defined as each original occurrence that meets the forensic evaluations requirements of SOVA and DSS.

FFS Children's Nutritional Counseling Program

Medicaid-eligible children under the age of 21 may receive unlimited E&M visits as long as the services are medically necessary.

This policy currently targets those obese individuals who do not meet the criteria for gastric bypass surgery or related services. Obesity is defined for this program as anyone under age 21 with BMI greater than or equal to 95th percentile for age.

Provider Services

A "provider" is defined as a physician, PA or NP meeting the licensure and educational requirements in South Carolina and/or the border states of Georgia and North Carolina.

During the child's routine physical or office visit, the provider must assess his or her need for obesity counseling intervention. The provider determining a need for obesity intervention must communicate with the child and his or her parents or legal guardian the weight loss goal and plans that lead to an incremental decrease in weight loss. The weight loss goals, laboratory work and exercise plan must be documented in the child's medical records.

The provider should schedule the child for an independent visit for an E&M service to treat him or her for obesity. The provider must bill the appropriate level E&M service and document provided services in the child's medical record.

The provider must emphasize the importance of exercise, develop a realistic exercise plan with goals, and document the visit in the child's medical record. Children must be accompanied by a

parent or legal guardian, and all treatment plans must be reviewed with a parent or legal guardian present. The provider will arrange for an individual nutritional assessment to be provided by a licensed and Medicaid-enrolled dietitian, if medically necessary.

The provider must schedule follow-up exams with both child and parent or legal guardian to evaluate the progress of the obesity treatment developed by the dietitian. The follow-up exam must review compliance with the treatment plan and must include a discussion regarding the child's progress toward meeting their treatment goals.

Dietician Services

The dietitian is responsible for reviewing the child's habits, providing dietary education for the child and his or her parent or legal guardian, reinforcing the importance of exercise, developing a nutritional plan and establishing weight goals. The dietitian must document the child's progress, activities, and compliance with the nutritional and exercise plan. A written progress report must be submitted within 48 hours of the nutritional counseling visit to the ordering provider each time the child is seen individually or in a group/class setting. The dietitian must maintain complete medical records of the nutritional and exercise plan, and the child's compliance with the treatment plan.

Additional Services

If the provider (or dietitian) has completed a series of six visits and the patient has been compliant with the obesity treatment plan and the provider (or dietitian) has determined that the patient would benefit from additional provider visits and nutritional counseling, the provider must submit documentation of medical necessity to:

SCDHHS

Attention: Medical Director

PO Box 8206

Columbia, SC 29202

In order to receive additional visits not to exceed six additional provider visits and six additional nutritional counseling sessions within a 12-month period, the following documentation must be submitted to SCDHHS by the physician, NP or PA only:

- A letter of medical necessity
- Patient notes
- BMI start and end
- A1C
- Dietitian reports
- Exercise plan and notes on adherence

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The South Carolina Healthy Connections Medicaid Program, in accordance with federal requirements, Section 1905(r) of the Social Security Act, has developed an EPSDT benefit for Medicaid-eligible children from birth to age 21.

EPSDT Standards

- To provide early health assessments for the child who is Medicaid eligible so that potential diseases can be prevented.
- To periodically assess the child's health for normal growth and development.
- To screen the child through simple tests and procedures for conditions needing closer medical attention.
- To diagnose the nature and cause of conditions requiring attention, by synthesizing findings of the health history and physical examination.
- To treat abnormalities detected in their preliminary stages or make the appropriate referral whenever necessary.

Services Covered under EPSDT

The EPSDT benefit in South Carolina provides comprehensive and preventive health services needed to diagnose and treat a child's health and developmental conditions as early as possible.

Periodic Screening Services

EPSDT covers regular screening services (check-ups) for infants, children and adolescents. At a minimum, children will receive services which constitute evaluations of their physical and mental health; their growth and development; vision, hearing and dental health; and their nutritional and immunization status.

The SCDHHS has adopted the Bright Futures/AAP Recommendations for Pediatric Preventive Health Services that is comprised of a set of periodic screenings and procedures applicable at each stage of the child's life, also called the "Periodicity Schedule".

The age-appropriate required periodic screenings and procedures during an EPSDT visit are as follows:

- Comprehensive Health and Physical Examination:
 - Includes history, measurements, unclothed age-appropriate physical examination.
- Sensory Screening:
 - includes vision and hearing.
- Developmental/Behavioral Health Screenings:
 - Includes a general screening as part of the EPSDT screening component.
- Procedures:
 - Includes laboratory tests and procedures.
- Appropriate Immunization:
 - If at the time of screening, it is determined that immunization is needed and appropriate to provide, then immunization treatment must be provided at that time. For an age-appropriate immunization schedule, the provider must reference the CDC at <https://www.cdc.gov/vaccines/vpd/vaccines-age.html>.
- Oral Health:
 - Includes oral screening at each visit and when applicable, fluoride varnish and fluoride supplementation.
- Health Education and Anticipatory Guidance:

- Includes age-appropriate health education (including anticipatory guidance) at each screening.

For details of pediatric preventive health care screening services and their frequency, please refer to the Bright Futures/AAP Periodicity Schedule at <https://msp.scdhhs.gov/epsdt/site-page/periodicity-schedule>.

Note: Additionally, the SCDHHS policy exceeds the frequency and coverage recommended by the AAP and providers are required to follow the South Carolina specific information for the following areas:

- Immunization:
 - For an age-appropriate immunization schedule, the provider must reference the CDC at: <https://www.cdc.gov/vaccines/schedules/hcp/index.html>.
 - Every visit should be an opportunity to update and complete a child's immunizations. If a child is unable to be immunized at the recommended time, the reason should be documented in the child's record.
- Developmental/Behavioral Health Assessments:
 - Follow-up developmental and behavioral health assessments are allowed as indicated by the general screening during a periodic or interperiodic visit.
- Lead Screening:
 - Children enrolled in Medicaid must receive blood lead screening at ages 12 months and 24 months. Additionally, any child between ages 24 and 72 months with no record of a previous blood lead screening test must receive one. The completion of a risk assessment does not meet SCDHHS requirements.
 - In collecting blood samples for lead testing, providers are required to follow the specimen and collection guidelines developed by the SCDHEC. These guidelines are available on the SCDHEC Bureau of Laboratories webpage at <http://www.scdhec.gov/health/lab>.
 - The South Carolina Code of Laws, Section 44-53-1380, mandates that any physician, hospital, public health nurse or other diagnosing person or agency must report known or suspected cases of lead poisoning to the SCDHEC within seven days. If you would like more information about the South Carolina Childhood Lead Poisoning Prevention Program, please call: +1 866 466 5323.

- Oral Health:
 - Oral screenings are performed during each EPSDT visit through the month of the beneficiary's 21st birthday. For details on physicians' oral health services, please refer to the SCDHHS Oral Health Section of the Periodicity Schedule at:
<https://msp.scdhhs.gov/epsdt/site-page/periodicity-schedule>

Interperiodic Screening Services

EPSDT also covers medically necessary "interperiodic" screenings outside of the periodicity schedule when there is an indication of a medical need to diagnose an illness or condition that was not present at the regularly scheduled screening or to determine if there has been a change in a previously diagnosed illness or condition that requires additional services.

Note: All health related problems that are identified during an EPSDT visit should include referral (when indicated) to the proper entity for further evaluation and treatment. Referrals may include such services and evaluations to determine the need for assistive technology if it is determined that these services are medically necessary and that the child may benefit from them. These services must be medical in nature and not for educational purposes.

Diagnostic Services

EPSDT covers diagnostic services when a screening indicates the need for further evaluation.

Treatment Services

- State Plan Covered Services:
 - EPSDT covers necessary health care services for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedure.
- Non-State Plan Covered Services — Medically Necessary Services:
 - Additional health care services are available under the federal Medicaid program if they are medically necessary to treat, correct or ameliorate illnesses and conditions discovered regardless of whether the service is covered by the South Carolina Medicaid State Plan. Medical necessity is determined by South Carolina Medicaid on a case-by-case basis. Arbitrary limitations on services are not allowed within the EPSDT benefit (e.g., one pair of eyeglasses or 10 PT visits per year). South Carolina Healthy Connections Medicaid will make the final determination as to which treatment it will cover among equally effective, available alternative treatments. All in-State resources must be exhausted prior to treatment outside of the State.

Additional Tests/Procedures

- Sickle Cell Test — A screening test is administered when indicated by family, medical history or in the presence of anemia.
- Parasites Test — A test for parasites is administered when indicated by medical history, physical assessment or a positive result of a previous test.
- Tuberculin Skin Test — Mantoux test (with five tuberculin units [TUs] of purified protein derivative [PPD] administered intradermally) should be considered for all children at increased risk of exposure to individuals with tuberculosis (TB). Providers may want to check with local, State or regional TB control officials (public health department) for more specific information relating to the epidemiology of TB in their area.
- Topical Fluoride Varnish — South Carolina Healthy Connections children can receive topical fluoride varnish during sick or well child visits from the eruption of their first tooth through the month of their 21st birthday. Children ages zero through six may receive a maximum of four applications per year, while children ages seven through 20 may receive one application per year.
- Developmental/Behavioral Health Assessments — Follow-up developmental and behavioral health assessments are allowed as indicated by the general screening during a periodic or interperiodic visit.

Transportation Services

Transportation services, including Non-Emergency Medical Transportation (NEMT), are available for EPSDT-eligible beneficiaries. To schedule NEMT trips to a medical appointment for beneficiaries not residing in a nursing facility, contact the Transportation Broker at: <https://memberinfo.logisticare.com/scmember/>. To schedule NEMT trips to a medical appointment for beneficiaries residing in a nursing facility, contact the nursing facility directly.

Beneficiary Eligibility for EPSDT Services by Provider Location

Based on the qualified healthcare practitioner's location, EPSDT services can be rendered to the beneficiaries as follows:

- In the physician's office:
 - EPSDT services can be rendered for beneficiaries ages 0–20 (through the month of the 21st birthday).
- In FQHCs:

- EPSDT services can be rendered for beneficiaries ages 0–20 (through the month of the 21st birthday).
- In RHCs:
 - EPSDT services can be rendered for beneficiaries ages 0–20 (through the month of the 21st birthday).
- In CCCs:
 - EPSDT services can be rendered only for children ages 5–20 (through the month of the 21st birthday).

Resources

To obtain a copy of the AAP Guidelines for Health Supervision please contact:

American Academy of Pediatrics
141 North West Point Boulevard
PO Box 927
Elk Grove Village, IL 60009-0927
+1 800 433 9016

To order the Denver II test forms, screening manual, test kit and training videotape contact:

Denver Developmental Materials, Inc.
PO Box 371075
Denver, CO 80237-5075
+1 303 355 4729

To obtain a hearing kit, contact:

BAM Work Market, Inc.
PO Box 10701
University Park Station
Denver, CO 80210

To obtain a new or reconditioned audiometer, contact:

Health and Hygiene/ELB
605 Eastowne Drive
Chapel Hill, NC 27514

To order growth charts, contact:

Ross Laboratories
Division of Abbott Labs
Columbia, OH 43216
+1 614 624 7677

Or

Mead Johnson and Company
Nutritional Division
Evansville, IN 47721
+1 812 429 5000
+1 800 227 5767

To order a well-child record system, contact:

Milcom
A Division of Hollister, Inc.
2000 Hollister Drive
Libertyville, IL 60048
+1 800 243 5546

To order Anticipatory Guidance/TIPP educational materials, contact:

Materials Library/Educational Resources
Department of Health and Environmental Control
Columbia, SC 29201
+1 803 898 3804

Pharmacy Services

Please see the Pharmacy Services Provider Manual for specific information regarding Pharmacy Services.

Durable Medical Equipment/Supply

Please see the Durable Medical Equipment (DME) Services Provider Manual for specific information regarding DME and Supply Services.

Services for AIDS Patients

In an effort to find a medical home for AIDS patients covered under the Medicaid program and to properly reimburse physicians for the complications involved with treating these patients, supplemental codes (see table below) have been developed for physicians treating Medicaid beneficiaries diagnosed with AIDS or AIDS Related Complex (ARC).

Additional Long Term Living Services

Aside from traditional Medicaid services (physician, hospital, drugs, etc.), SCDHHS offers home- and community-based services (HCBS) waiver through the Division of CLTC. In addition to being HIV positive, the individual must meet an established medical level of care prior to receiving these services. Services available are listed below:

- Case management services
- Private duty nursing services
- Personal care aide services
- Modified and therapeutic-diet home-delivered meals
- Counseling services
- Foster care services
- Limited nutritional supplements
- Environmental modifications
- Attendant care
- Home management
- Two additional prescription drugs per month

Incontinence Products

For incontinence products policy and procedures, please refer to the Home Health Services Provider Manual located on the SCDHHS website at: <http://www.scdhhs.gov/contact-us>.

CLTC Offices

There are 11 areas and three satellite CLTC offices Statewide. Each office is staffed by service managers who are professional social workers and Registered Nurses. These service managers work with the person and/or the family to plan and coordinate the services the beneficiary may need.

If you have clients, who you feel may benefit from any of these services, or if you have questions about the CLTC program, please call your area CLTC office as listed in the table on the following page.

For additional information, please contact the PSC at: +1 888 289 0709, submit an online inquiry <http://www.scdhhs.gov/contact-us>, or write to:

SCDHHS
Community Long-Term Care Department
PO Box 8206
Columbia, SC 29202

AREAS	COUNTIES SERVED	PHONE NUMBERS
Area 1 — Greenville	Greenville, Pickens	+1 864 242 2211 +1 888 535 8523
Area 2 — Spartanburg	Cherokee, Spartanburg, Union	+1 864 587 4707 +1 888 551 3864
Area 3 — Greenwood, IMS	Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	+1 864 223 8622 +1 800 628 3838
Area 4 — Rock Hill	Chester, Lancaster, York	+1 803 327 9061 +1 888 286 2078
Area 5 — Columbia	Fairfield, Lexington, Newberry, Richland	+1 803 741 0826 +1 888 847 0908
Area 6 — Orangeburg	Allendale, Bamberg, Calhoun, Orangeburg	+1 803 536 0122 +1 888 218 4915
Area 6A — Aiken Satellite Office	Aiken, Barnwell	+1 803 641 7680 +1 888 364 3310
Area 7 — Sumter	Clarendon, Kershaw, Lee, Sumter	+1 803 905 1980 +1 888 761 5991
Area 8 — Florence	Chesterfield, Darlington, Dillon, Florence, Marlboro	+1 843 667 8718 +1 888 798 8995
Area 9 — Conway	Georgetown, Horry, Marion, Williamsburg	+1 843 248 7249 +1 888 539 8796
Area 10 — Charleston	Berkeley, Charleston, Dorchester	+1 843 529 0142 +1 888 805 4397
Area 10A — Point South Satellite	Beaufort, Colleton, Hampton, Jasper Beaufort	+1 843 726 5353 +1 800 262 3329 +1 843 521 9191

AREAS	COUNTIES SERVED	PHONE NUMBERS
Area 11 — Anderson, IMS	Anderson, Oconee	+1 864 224 9452 +1 800 713 8003

Outpatient Pediatric Aids Clinics

Outpatient Pediatric AIDS Clinics (OPACs) are designed to provide specialty care, consultation, and counseling services for HIV infected and exposed, Medicaid-eligible children and their families. Clinics presently contracted are located at the Medical University of South Carolina (MUSC), Department of Pediatrics; the USC School of Medicine, Department of Pediatrics; and Greenville Hospital. The mission of OPAC is to follow children who have been exposed to HIV perinatally as children born to women infected with HIV.

Alcohol and Drug Abuse Rehabilitation Services

The medical benefits package for Medicaid beneficiaries includes OP alcohol and drug (A&D) rehabilitative services. Crisis Management is also available for patients who are experiencing emotional, physical and/or psychological trauma.

The effectiveness of this program relies on the referrals by physicians. There are several alternatives a physician can use to refer a Medicaid beneficiary for A&D services. Likewise, there are several ways to bill for referral services.

Initial Medical Assessment and Referral

Face-to-face contact between physician and client to assess the patient status, provide diagnostic evaluation screening, and provide physician's referral for A&D rehabilitative services should be billed using the appropriate code. This includes the completion of the A&D Medical Assessment signed and dated by the physician. A sample copy of the form can be found in the Forms section of the provider portal. Additional forms are available upon request from your county A&D abuse program. This form will be placed in the client's file at the local A&D abuse authority site. A copy should be retained in the patient's file. The assessment form completion is included in the reimbursement fee.

Local Alcohol and Drug Authorities Currently Enrolled in Medicaid

The chart beginning on the following page includes an address and telephone number for all of the local A&D authorities currently enrolled in Medicaid:

COUNTY	PROGRAM NAME AND ADDRESS	TELEPHONE NUMBER
	South Carolina Department of Alcohol and Drug Abuse (DAODAS)	
	101 Executive Center Drive, Suite 215	+1 803 896 5555
	Columbia, South Carolina 29210	
	Cornerstone	
Abbeville	112 Whitehall Street	+1 864 366 9661
	Abbeville, South Carolina 29620	
	Aiken Center	
Aiken	1105 Gregg Highway	+1 803 649 1900
	Aiken, South Carolina 29801	
	New Life Center	
Allendale	570 Memorial Avenue	+1 803 584 4238
	Allendale, South Carolina 29810	
	Anderson/Oconee Behavioral Health Services	
Anderson	226 McGee Road	+1 864 260 4168
	Anderson, South Carolina 29625	
	Dawn Center (Tri-County Commission of A&D Abuse)	
Bamberg	608 North Main Street	+1 803 245 4360
	Bamberg, South Carolina 29003	
	Axis I Center of Barnwell	
Barnwell	644 Jackson Street	+1 803 541 1245
	Barnwell, South Carolina 29812	
	Beaufort County Department of Alcohol and Other Drug Services	
Beaufort	1905 Duke Street	+1 843 470 4545
	Beaufort, South Carolina 29901	
	Ernest E. Kennedy Center	
Berkeley	306 Airport Drive	+1 843 761 8272
	Monks Corner, South Carolina 29461	
	Dawn Center (Tri-County Commission of A&D Abuse)	

COUNTY	PROGRAM NAME AND ADDRESS	TELEPHONE NUMBER
Calhoun	Herlong Extension Industrial Park	+1 803 655 7963
	St. Matthews, South Carolina 29135	
	Charleston Center	
Charleston	5 Charleston Center Drive	+1 843 958 3300
	Charleston, South Carolina 29401	
	Cherokee County Commission of Alcohol and Other Drug Services	
Cherokee	201 West Montgomery Street	+1 864 487 2721
	Gaffney, South Carolina 29341	
	Hazel Pittman Center	
Chester	130 Hudson Street	+1 803 377 8111
	Chester, South Carolina 29706	
	Alpha Center	
Chesterfield	1218 East Boulevard	+1 843 623 7062
	Chesterfield, South Carolina 29709	
	Clarendon County Commission on ADA	
Clarendon	14 North Church Street	+1 803 435 2121
	Manning, South Carolina 29102	
	Colleton County Commission on ADA	
Colleton	1439 Thunderbolt Drive	+1 843 538 4343
	Walterboro, South Carolina 29488	
	Rubicon Inc.	
Darlington	510 East Carolina Avenue	+1 843 332 4156
	Hartsville, South Carolina 29550	
	Trinity Behavioral Care	
Dillon	204 Martin Luther King Jr. Blvd.	+1 843 774 6591
	Dillon, South Carolina	
	Dorchester Alcohol & Drug Commission	

COUNTY	PROGRAM NAME AND ADDRESS	TELEPHONE NUMBER
Dorchester	500 North Main Street, Suite 4	+1 843 871 4790
	Summerville, South Carolina 29483	
	Cornerstone	
Edgefield	400 Church Street, Room 112	+1 803 637 4050
	Edgefield, South Carolina 29824	
	Fairfield County Substance Abuse Commission	
Fairfield	200 Calhoun Street	+1 803 635 2335
	Winnsboro, South Carolina	
	Circle Park Behavioral Health Services	
Florence	601 Gregg Avenue	+1 843 665 9349
	Florence, South Carolina 29501	
	Georgetown County ADA Commission	
Georgetown	1423 Winyah Street	+1 843 546 6081
	Georgetown, South Carolina 29440	
	The Phoenix Center	
Greenville	1400 Cleveland Street	+1 864 467 3739
	Greenville, South Carolina 29607	
	Cornerstone	
Greenwood	1510 Spring Street	+1 864 227 1001
	Greenwood, South Carolina 29646	
	New Life Center	
Hampton	102 Ginn Altman Avenue, Suite C	+1 803) 943-2800
	Hampton, South Carolina 29924	
	Shoreline BHS	
Horry	2404 Wise Road	+1 843 365 8884
	Conway, South Carolina 29526	
	New Life Center	
Jasper	113 East Wilson Street	+1 843 726 5996
	Ridgeland, South Carolina 29936	

COUNTY	PROGRAM NAME AND ADDRESS	TELEPHONE NUMBER
	Alpha Center	
Kershaw	709 Mill Street	+1 803 432 6902
	Camden, South Carolina 29020	
	Counseling Services of Lancaster	
Lancaster	114 South Main Street	+1 803 285 6911
	Lancaster, South Carolina 29720	
	Gateway Counseling Center	
Laurens	219 Human Services Road	+1 864 833 6500
	Clinton, South Carolina 29325	
	The Lee Center Family Counseling and Addiction Services	
Lee	108 East Church Street	+1 803 484 6025
	Bishopville, South Carolina 29010	
	Lexington/Richland Alcohol and Drug Abuse Council	
Lexington	130 North Hospital Drive	+1 803 733 1390
	West Columbia, South Carolina 29169	
	Trinity Behavioral Care	
Marion	103 Court Street	+1 843 423 8292
	Marion, South Carolina 29571	
	Trinity Behavioral Care	
Marlboro	211 North Marlboro Street, 2nd Floor	+1 843 479 5683
	Bennettsville, South Carolina 29512	
	Cornerstone	
McCormick	504 North Mine Street	+1 864 465 2631
	McCormick, South Carolina 29835	
	Westview Behavioral Health Services	
Newberry	800 Main Street or 909 College Street	+1 803 276 5690
	Newberry, South Carolina 29108	
	Anderson/Oconee Behavioral Health Services	

COUNTY	PROGRAM NAME AND ADDRESS	TELEPHONE NUMBER
Oconee	691 South Oak Street	+1 864 882 7563
	Seneca, South Carolina 29678	
	Dawn Center (Tri-County Commission of Alcohol and Drug Abuse)	
Orangeburg	910 Cook Road	+1 803 536 4900
	Orangeburg, South Carolina 29118	
	Behavioral Health Services of Pickens County	
Pickens	309 East Main Street	+1 864 898 5800
	Pickens, South Carolina 29671	
	Lexington/Richland Alcohol and Drug Abuse Council	
Richland	2711 Colonial Drive	+1 803 726 9300
	Columbia, South Carolina 29203	
	Saluda Behavioral Health System	
Saluda	204 Ramage Street	+1 864 445 2968
	Saluda, South Carolina 29138	
	Spartanburg County Alcohol and Drug Abuse Commission	
Spartanburg	187 West Broad Street, Suite 200	+1 864 582 7588
	Spartanburg, South Carolina 29306	
	Sumter County Commission on ADA	
Sumter	115 North Harvin Street, 3rd Floor	+1 803 775 6815
	Sumter, South Carolina 29150	
	Union county Commission on ADA	
Union	201 South Herdon Street	+1 864 429 1656
	Union, South Carolina 29379	
	Williamsburg Commission on ADA	
Williamsburg	115 Short Street	+1 843 354 9113
	Kingstree, South Carolina 29556	
	Keystone Substance Abuse Services	

COUNTY	PROGRAM NAME AND ADDRESS	TELEPHONE NUMBER
York	199 South Herlong Avenue	+1 803 324 1800
	Rock Hill, South Carolina 29732	

Alcohol and Drug Testing Policy

Effective for dates of service beginning January 1, 2016, the SCDHHS will cover the following presumptive and definitive drug testing classifications. SCDHHS will reimburse for a maximum of one screening per procedure code, per DOS, not to exceed 18 screenings per 12-month period. Providers should bill the most appropriate Healthcare Common Procedure Coding System (HCPCS) code for the service rendered.

Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per DOS.

Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per DOS.

Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods [e.g., alcohol dehydrogenase]); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1–7 drug class(es), including metabolite(s) if performed.

SCDHHS policy has been and continues to be that A&D screenings, as with all lab tests, must be ordered by a qualified practitioner operating within their scope of practice and as allowed by State Law. Qualified practitioners may authorize certain laboratory tests to be performed at defined intervals over a period of 60 days with one “standing order” only when used in connection with an extended course of treatment for substance abuse disorders. The ordering practitioner must document in the beneficiary’s clinical record the medical necessity for the testing and the results of each test. Qualified practitioners ordering unnecessary tests for which Medicaid is billed may be subject to civil penalties.

A qualified practitioner is defined as a physician, NP or a PA. The qualified practitioner may write an individualized standing order for the beneficiary, but must be updated every 60 days.

Laboratory standing orders must be in a written form, patient specific, and include a duration that cannot exceed 60 days. In all instances, standing orders are rendered invalid after 60 days from the date the initial test was ordered. Existing standing orders must be reviewed regularly to ensure their continuing validity.

Standing orders must include the following information:

- The treating physician, NP or PA name, address, telephone number, license number and NPI number.
- The name, date of birth, sex, Medicaid ID number, diagnosis and statement of clinical symptoms that justify medical necessity of the beneficiary for whom the tests are ordered.
- The date the test was ordered.
- The name of all tests performed, listed individually.
- Specific intervals, at which each individual test should be performed, based on the individual treatment needs.
- Signature, title and date of qualified practitioner that evaluated the beneficiary and confirmed the medical necessity.

A&D screens for employment purposes or for a court ordered A&D screen are not covered under the Medicaid program.

Tobacco Cessation

Tobacco use is the leading cause of preventable disease and premature death in South Carolina. SCDHHS provides comprehensive coverage for tobacco cessation treatment through pharmacotherapy and counseling for all full-benefit Medicaid beneficiaries. SCDHHS also partners with SCDHEC to communicate about programs available to assist Medicaid beneficiaries with quitting tobacco use.

Providers are encouraged to screen beneficiaries for tobacco use during medical encounters and document nicotine dependence using the appropriate diagnosis codes.

Medication

SCDHHS covers prescriptions for the following tobacco cessation and NRT products:

- Bupropion SR products for tobacco use (Zyban)
- Varenicline (Chantix) tablets
- Nicotine gum
- Nicotine lozenge
- Nicotine nasal spray
- Nicotine inhaler
- Nicotine patch

Tobacco cessation products are exempt from the adult monthly prescription limit, prior authorization, and copayment requirements. There is no limit to the number of quit attempts in a calendar year. The following medically appropriate combination therapies are also covered:

- Long-term nicotine patch + other NRT product (gum or spray)
- Nicotine patch + nicotine inhaler
- Nicotine patch + Bupropion SR

General edits on day supply are based on product dosing in manufacturer package inserts. Prescribers are encouraged to reference the AAFP Pharmacologic Product Guide for FDA-approved medications for smoking cessation for more information on product guidelines.

As with all other pharmaceuticals, SCDHHS reimburses only rebated products (brand or generic) for FFS beneficiaries. A beneficiary must provide a prescription to receive any medication, including OTC products. A dual-eligible member can receive OTC products through Medicaid coverage, but the individual's Medicare Part D prescription drug plan must cover prescriptions for legend (non-OTC) tobacco cessation products.

For further questions about this benefit, prescribers should contact the Magellan Medicaid Administration's Clinical Call Center at: +1 866 247 1181.

Counseling

SCDHHS policy requires that all tobacco cessation treatment must be ordered by a qualified practitioner defined as a physician, NP, CNM or PA. Medical documentation including time spent counseling the patient, treatment plan, and pharmacotherapy records must be maintained in the patient record.

South Carolina Tobacco Quitline

One-on-one telephone counseling with web-based support are available to all South Carolinians without charge through the South Carolina Tobacco Quitline. Participants in the Quitline program are connected with a personal Quit Coach, who helps the participant develop a quit plan and uses cognitive behavioral coaching and motivational interviewing techniques to support the quit process. This evidence-based program has been clinically proven to help participants quit tobacco use, and tailored programs are available for Hispanic, Native American, pregnant and youth callers, and smokeless tobacco users, as well as participants who have chronic medical and mental health conditions.

SCDHHS strongly encourages prescribers and pharmacists to refer patients to the South Carolina Tobacco Quitline at: +1 800 QUIT NOW. Services are available 24 hours a day, seven days a week. Additional information is available at:

<http://www.scdhec.gov/Health/TobaccoCessation/HelpYourPatientsQuit/>

Hospice

Please see the Hospice Services Provider Manual for specific information regarding Hospice Services.

Inpatient and Outpatient Hospital Services**General Policy Guidelines**

Services performed by the physician in a hospital are compensable if medically necessary. Special procedures are compensable if deemed a separate and reimbursable service. Services or supplies administered by the hospital or hospital employee are considered a part of the overall hospital service and are reimbursable only under the hospital allowable costs.

A physician who is either salaried or contracted by the hospital (a hospital-based physician), and who performs services under said contract or employment, may not bill for those services separately under his or her individual Medicaid provider number. The contracting hospital may claim these services under the professional fees allowable for the hospital under its hospital-based physician Medicaid number.

Levels of Service

The terminology for levels of service as defined in the American Medical Association (AMA) CPT guidelines will be recognized. The medical record must reflect the level of service billed.

Records and Documentation Requirements

Both the physician and hospital are expected to comply with South Carolina Medicaid policy in providing the agency with medical records if requested.

Hospital Visits

Initial Hospital Care

Please refer to the current CPT when multiple E&M services are prescribed on the same date as initial hospital care.

Only one physician for each hospital admission is reimbursed. If two physicians of different specialties perform a comprehensive exam on admission day, one may use a consultation code (with the exception of a transfer), as long as the service meets the criteria of a consultation.

A comprehensive level of service is not allowed for readmission for the same illness or problem. A reduced level of service must be used if the patient is discharged and readmitted.

If a patient is transferred from one hospital to another, the receiving physician may bill for a comprehensive level of service (even if the transfer occurs on the day of admission).

Initial hospital care codes are exempt from the surgical package. For instructions on surgical package billing, please refer to General Surgery Guidelines within this section of the manual.

Subsequent Hospital Care

Subsequent hospital care is generally allowable one visit per day, per physician.

Post-operative visits by the surgeon are not allowed as a separate reimbursement since the visits are included in the surgical package unless the surgical procedure is not part of a surgical package.

Subsequent hospital care codes will "multiply" and should be reported as one-line item, with the number of visits indicated in the "units" column.

Hospital Discharge

Hospital discharge is a covered service. This charge is acceptable only if **billed in lieu of a hospital visit code**. It may not be charged if a surgical procedure was performed and the surgery is considered a surgical package. Reimbursement is made for only one physician for each hospital discharge.

Concurrent Care Guidelines

When two or more physicians render subsequent hospital care, consultations (office or inpatient), critical care, emergency room (ER), nursing home, rest home or office medical care to the same patient at the same time, this is referred to as "medical concurrent care".

Concurrent Care Criteria

If physicians of the same specialty or similar specialty render care for the same condition at the same time, benefits are provided only for the attending physician.

When two physicians render care for unrelated conditions at the same time, benefits are provided to each physician if both of the following apply:

- The physicians are not of the same or similar specialty.
- Each physician is treating the patient for a condition unique to his specialty.

Medical/Surgical

Benefits are provided for in-hospital medical services performed by a physician other than the admitting surgeon in addition to benefits for in-hospital surgical services under the following circumstances:

- The medical care rendered was not related to the condition causing surgery and was not part of routine pre- and post-operative care.
- The medical care required supplemental skills not possessed by the attending surgeon.
- A physician other than a surgeon admits a patient for medical treatment, and the need for surgery arises later during the hospitalization.
- A cardiovascular surgeon performs cardiac surgery and a cardiologist follows the patient during hospitalization even though the diagnosis is the same.

Critical Care Services

Follow current CPT guidelines indicating services are considered a part of critical care and not reimbursed separately. Up to four hours of critical care per day are allowed. Critical care must be billed per DOS. Critical care services are not included in the surgical package and may be billed separately.

EKG interpretations would not be covered separately when performed as part of, or in conjunction with, critical care.

Critical Care, first hour is used to report the services of a physician providing constant attention to an unstable, critically ill patient for a total of 30 minutes to 74 minutes on a given day. Reimbursement is limited to one per day. If the total duration of critical care on a given day is less than 30 minutes, the appropriate E&M code should be used. In the hospital setting, the higher level code would most often apply. Time must be clearly documented in the medical record.

Critical Care, each additional 30 minutes is used to report the services of a physician providing constant attention to an unstable, critically ill patient for up to 30 minutes beyond the first 74 minutes of care on a given day.

Reimbursement is limited to six per day for a total of three hours per day. Time must be clearly documented in the medical record.

Prolonged Services

Medicaid will reimburse for prolonged physician services with direct (face-to-face) patient contact.

Documentation for CPT codes must clearly indicate that the service provided was direct (face-to-face) contact between the physician and the patient for more than one hour beyond the usual service for the level of E&M code billed. These codes are billed in addition to the appropriate E&M code. Please refer to the CPT guidelines for coding these services. Prolonged Services each additional 30 minutes are non-covered.

Prolonged Physician Services without Direct (face-to-face) Patient Contact will remain non-covered.

ER Services

Outside Attending Physician

A private physician called to the hospital in an emergency situation may bill for ER services in the following instances:

- When a hospital-based ER physician is not available.
- The physician is called in by the ER physician.
- If a life-threatening situation develops.

Hospital-Salaried or Hospital-Based ER Physicians

Medicaid has established policies and procedures for OP hospital services to distinguish between OP clinic services and ER services. Since some hospitals do not have separate and distinct OP clinics, the ER physician must designate in the patient's records if the patient's visit to the ER was actually an emergency situation.

Professional services rendered in an OP hospital environment must be charged on a CMS-1500 form. If a hospital-based or salaried physician renders a professional service in an ER, all services must be charged separately by submitting a CMS-1500 or by using a PAID or billing through the PAID Spin Off Program.

The physician's service must be charged using an appropriate CPT code. Procedures identifiable as a unique and separate service may be reported separately.

Levels of Service

Each level of service includes examinations, evaluations, and treatments that are medically necessary, and that are presented as an emergency in a hospital ER setting. These levels of service exclude the interpretation of diagnostic tests. Medicaid will only reimburse for one ER visit per day for the same or related diagnosis.

Emergency Life Support

Physician direction of an emergency medical system (EMS) or ambulance transport service for advanced life support is covered when medically indicated. The service is compensable, in addition to other medically necessary services performed by a physician. Emergency services performed by other hospital professionals are considered part of a technical charge by the hospital and may not be billed or charged as a separate professional service.

Transportation of Self-Administered Oxygen Dependent Beneficiaries

This policy applies to beneficiaries who are admitted, as an inpatient of a hospital or hospital ER, are oxygen dependent and currently do not have their portable oxygen system in their possession, and do not require transportation via ambulance for their return trip to their residence for any other reason. The hospital is responsible for arranging and acquiring a portable oxygen system complete with all medically necessary accessories, upon discharge. Hospitals and ambulance providers will no longer receive reimbursement for non-essential, non-medically necessary ambulance transportation for self-administered oxygen dependent beneficiaries. All provider types and services are subject to post payment review by the Division of PI.

It is the responsibility of both the hospital and DME provider to coordinate and dispense oxygen to the Medicaid beneficiary who is currently admitted to the hospital or hospital ER in order for the appropriate mode of non-emergent transportation to be arranged with the transportation broker upon discharge. The dispensing DME provider will be responsible for arranging the return of the portable oxygen system dispensed by their company at the time of discharge from the admitting hospital facility.

SCDHHS will reimburse for a portable oxygen system billed with a U1 modifier, and the dispensing DME provider will be reimbursed per occurrence. SCDHHS will limit the number of occurrences per patient to no more than three occurrences per calendar month. Services that exceed three occurrences per calendar month will not be reimbursed.

It is the responsibility of EMS providers whenever possible to transport oxygen dependent beneficiaries with the beneficiary's personal portable oxygen system in anticipation of the beneficiary's medical/health needs.

Observation Unit

Medicaid will sponsor the professional reimbursement for E&M services provided to patients requiring observation in a hospital. Please refer to the current CPT for coding guidelines. Observation codes should be billed with place of service 22.

Administrative Days

Medicaid sponsors Administrative Days in any South Carolina-enrolled acute care hospital and acute care hospitals enrolled within the South Carolina service area for Medicaid-eligible patients who no longer require acute hospital care but are in need of nursing home placement that is not available at the time.

Physicians who are treating these patients can bill for their services rendered to these patients using the same procedure codes that they use for their patients in nursing homes and rest home facilities. The specific code you use would depend on whether it is a new or established patient and on the level of care given. Use place of service 21 when billing.

One limited examination per 30 days is required for all Administrative Day patients. Additional visits may be allowed if medical justification is submitted.

Obstetrics and Gynecology**Pregnancy Determination**

An examination to determine if a patient is pregnant should be coded as an office E&M visit. The exception would be if a positive pregnancy test was determined and the provider performed an initial OB exam in the same visit.

Healthy Mothers/Healthy Futures Obstetrical Program

Obstetrical care provided under the Healthy Mothers/Healthy Futures program (HM/HF) must be billed as separate charges (fragmented), not as global OB care. The program includes increased reimbursement for health education, referral to the Women, Infants, and Children (WIC) program at the local county health department, and follow-up on missed appointments.

Standard obstetrical care, without the previously listed enhanced services, is also compensable. All services must be documented in the patient's chart.

HM/HF Checklist

One way of documenting the additional services is the HM/HF checklist. A sample copy of the checklist can be found in the Forms section of provider portal. The checklist is only an option for documenting services, and is by no means a requirement. The only requirement is that services be documented. If a practice chooses to use the HM/HF checklist, the physicians should sign and date the back of the checklist at the time of the initial visit so that it is not forgotten at a later date.

It is not necessary to cover all of the educational components on the checklist with each patient, but only the ones that pertain to each individual patient's health. If one component is discussed with the patient on more than one occasion, it may be checked and dated for each time. It is very important that at least one educational component on the checklist be checked and dated for each HM/HF enhanced visit that is billed to Medicaid.

Best Practice Guidelines for Perinatal Care (Replaces HRCP)

The HRCP, a Freedom of Choice Waiver program that encouraged risk-appropriate care for Medicaid sponsored pregnant women and infants, expired on August 11, 2001. Because the waiver expired, SCDHHS transitioned to recommended best practice guidelines for perinatal care.

South Carolina Medicaid remains committed to the concept(s) of risk-appropriate care and enhancing maternal and child health outcomes. Therefore, the following Medicaid Best Practice guidelines are recommended:

- Early and continuous risk screening should be provided for all pregnant women.
- Early entry into prenatal care should be encouraged.
 - Care for all prenatal women should be delivered by the provider level and specialty best suited to the risk of the patient. (AAP, American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. 8th ed. Elk Grove Village (IL): AAP; Washington, DC: American College of Obstetricians and Gynecologists, 2017.)
 - All infants should receive risk-appropriate care in a setting that is best suited to the level of risk presented at delivery. (AAP, American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. 8th ed. Elk Grove Village (IL): AAP; Washington, DC: American College of Obstetricians and Gynecologists, 2017.)
 - Risk assessment of the infant should be performed prior to discharge from the hospital.
 - Every Medicaid-eligible mother and infant should receive a Postpartum/Infant Home Visit.
 - Effective communication/coordination regarding the perinatal plan of care between each provider is essential (i.e., the specialist physician should communicate pertinent information back to the community-level physician).
 - A medical home should be established for the mother-infant unit after delivery to handle the long-term health care needs.
 - P/RSPCE referrals should be made when medically indicated.

For additional recommendations and guidelines for risk-appropriate ambulatory prenatal care for pregnant women, the “Guidelines for Perinatal Care,” which are endorsed by the AAP and the American College of Obstetrics and Gynecology (ACOG) may be referenced.

Ultrasounds

SCDHHS policy allows three obstetrical ultrasounds per pregnancy for OB/GYN providers. Ultrasounds in the first trimester are performed to establish viability, gestational age or to detect malformations. Two additional ultrasounds, performed during the second or third trimester, establishes more detailed anatomy and/or interval growth.

Additional Services

Fetal Biophysical Profile

Fetal biophysical profiles must also be medically justified. The medical record must reflect medical necessity.

Amniocentesis

Amniocentesis is a covered service when medically necessary. Justification must be documented in the medical record. Please refer to Genetic Studies within this manual for coverage criteria. Reimbursement is the same in the office or hospital (do not use 26 modifier for place of service 21 or 22).

Ultrasound for Amniocentesis Guidance

When performed in the hospital, do not use the 26 modifier since the code is for supervision and interpretation only.

Non-Stress Test

Non-stress tests (NSTs) are reimbursed when medically necessary. Reimbursement is not allowed when performed in the hospital by hospital personnel. If the physician provides the interpretation in place of service 21 or 22, he or she should bill with the 26 modifier. The physician’s interpretation of the NST must be clearly documented in the patient’s record.

Tocolytic

Tocolysis is non-compensable as a separate reimbursement under the Physician Services program. If a patient is admitted for tocolysis, the physician may bill for the appropriate hospital visits, prolonged services, or critical care services when applicable. The medical record must reflect the level of service billed. Tocolysis agents and monitoring are considered an integral part of the hospital allowable charged.

Lab Procedures

If the physician sends a specimen to an independent lab, the lab will bill for their services.

- The collection of a urine specimen is included in the office visit.
- Finger/heel/ear stick for collection of specimen(s) will be included in office visit reimbursement or lab test reimbursement and may not be billed as collection of venous blood by venipuncture. Lab tests performed in the office may be billed as a separate charge by billing the appropriate code allowed by the laboratory's CLIA certification category. Medicaid does not reimburse the maternal care provider for tests performed at an independent lab.

Venipuncture

When performing a venipuncture, bill the service as collection of venous blood by venipuncture. No documentation is required to be sent with the claim. If more than one venipuncture is performed on the same DOS, the claim must be billed hard copy with documentation of the number of venipunctures attached.

Non-Self-Injectable Drugs

The physician must provide any drugs that are not self-injectable and bill Medicaid the appropriate procedure code for the cost of the drug in addition to the procedure code for the administration of the drug. A physician may not write the patient a prescription for the medication to be filled at a pharmacy with the expectation that the beneficiary return to the physician's office for administration. The pharmacy will not be reimbursed for the prescription.

Enhanced Services for Pregnant Women Offered by SCDHEC

In addition to traditional medical care, pregnant women often have nutritional, environmental, psychosocial, and educational needs that may influence pregnancy outcomes.

In an effort to address these needs, all Medicaid pregnant women are eligible for the following Family Support Services through SCDHEC:

- Psychosocial Intervention — Patients may be referred to SCDHEC for services by an appropriately credentialed social worker for an assessment followed by services based on an individualized plan of care (IPOC).
- Nutritional Services — Patients may be referred to SCDHEC for services by an appropriately credentialed nutritionist or dietitian for an assessment followed by treatment that responds to individual patient needs and problems.
- Health Education — Information and process-oriented activities may be provided on an individual or group basis to predispose, enable, or reinforce patient adaptation or behavior conducive to health at the local health department.

For information on referrals to authorized providers of these services, call the PSC at: +1 888 289 0709 or submit an online inquiry at: <http://www.scdhhs.gov/contact-us>.

17 Alpha Hydroxyprogesterone Caproate (Makena® and 17P)

Effective December 20, 2013, SCDHHS will cover both Makena® and compounded hydroxyprogesterone caproate without a prior authorization. SCDHHS currently covers the use of 17 alpha hydroxyprogesterone caproate (17-P) intramuscular injections to support the prevention of preterm births. The therapy is considered effective in reducing negative outcomes and improving the quality of care in pregnant women. Makena® and compounded 17-P will be covered on a weekly basis beginning at 16 weeks' gestation through 36 weeks' gestation when the patient presents with a history of spontaneous preterm delivery in a single pregnancy, before 37 weeks gestation. All other risk factors for preterm delivery and for the use of hydroxyprogesterone caproate are considered investigational and not medically necessary.

Perinatal Care

Emergency Room Visit

When the physician meets the maternal patient in the ER or labor and delivery unit for immediate medical attention, the appropriate level emergency department code should be billed.

Observation Admission

When the physician meets the maternal patient at the ER or labor and delivery unit and admits the patient to the hospital for observation (less than 24 hours), the physician may bill the appropriate level hospital observation code with place of service 22.

External Version

External version is reimbursable as a separate procedure. The physician may bill this procedure in addition to the delivery charge. If applicable, prolonged services may also be billed. The medical record must document the service billed. This procedure is compensable at 100% of the established rate when performed on the same day of delivery.

Note: No assistant is allowed for this procedure.

Uncomplicated (Routine) Deliveries

Both vaginal and Caesarean section (C-section) deliveries are considered surgical packages. The following are inclusive in the surgical packages:

- Pitocin induction
- Surgical or mechanical induction
- Fetal monitoring (internal or external)
- Amnioinfusion

- Episiotomy
- Laceration repair
- Suture removal
- Standby for delivery
- Subsequent routine hospital care
- Hospital discharge
- Any related E&M visits within 30 days following the delivery
- Routine follow-up care (one postpartum visit may be billed separately using the appropriate code. Please refer to Postpartum Care under Obstetrics and Gynecology in this section of the manual).
- Insertion of cervical dilator (e.g., laminaria, prostaglandin) is considered included in the surgical package and may not be billed in addition to the CPT code for the delivery. This applies whether being placed the day of delivery, or several days prior to delivery, if placed by the delivering physician or physician within the same practicing group.

Providers are required to append the following modifiers, and in some cases complete the ACOG Patient Safety Checklist or a comparable patient safety justification form, when scheduling an induction of labor or a planned C-section for deliveries less than 39 weeks' gestation. The provider is responsible for maintaining a copy of this documentation in their files and in the hospital record, which are subject to SCDHHS PI review.

Providers should append the following modifiers to all CPT codes when billing for vaginal deliveries and C-sections:

- GB — 39 weeks' gestation and or more:
 - For all deliveries at 39 weeks' gestation or more regardless of method (induction, C-section or spontaneous labor).
- CG — Less than 39 weeks' gestation:
 - For deliveries resulting from patients presenting in labor, or at risk of labor, and subsequently delivering before 39 weeks, or

- For inductions or C-sections that meet the ACOG or BOI-approved medically necessary guidelines, the appropriate ACOG Patient Safety Checklist must be completed and maintained for documentation in the patient's file, or
- For inductions or C-sections that do not meet the ACOG or BOI-approved medically necessary guidelines, the appropriate ACOG Patient Safety Checklist must be completed. In addition, the provider must obtain approval from the regional perinatal center's MFM physician and maintain this documentation in the patient's file.

No Modifier — Elective Non-Medically Necessary Deliveries Less Than 39 Weeks' Gestation

For deliveries less than 39 weeks' gestation that do not meet ACOG or approved BOI guidelines, or are not approved by the designated regional perinatal center's MFM physician.

Delivery in Cases of Prolonged Labor

Effective with dates of service on or after January 1, 2012, SCDHHS modified the delivery policy in cases of prolonged labor when a vaginal delivery with failure to progress converts to a C-section. For beneficiaries that have been admitted to the hospital and have been in active labor for at least six hours, the procedure code and modifier UA should be used when billing for the C-section delivery. The patient records must indicate the time the beneficiary was admitted to the hospital with active labor and the start time of the C-section. All claims and reimbursements are subject to an audit by the Division of Program Integrity.

Hospital Admission for Delivery

The hospital admission codes are not allowed if the delivering physician or group has provided prenatal care to the beneficiary. The appropriate level admission code may be billed with drop-in vaginal and C-section deliveries only.

Emergency Deliveries

If the patient gives birth outside the hospital setting and the patient's private physician did not perform the delivery, but later meets the maternal patient at the hospital for post-delivery services, the following procedures apply:

- The private physician should bill for delivery of the placenta, if applicable.
- The private physician may also bill for subsequent hospital care and the hospital discharge, if applicable.

If a hospital-based physician actually performs the delivery and the private physician arrives in time to assist the hospital-based physician or arrives shortly after the delivery, the following apply:

- The hospital-based physician would bill for the delivery.
- The private physician would bill for the post-delivery services if the private physician performed the services.
- The private physician may also bill for subsequent hospital care and the hospital discharge, if applicable.

If the private physician is not involved in the delivery or post-delivery services, then the following applies:

- The physician may bill for the admission (if appropriate), subsequent hospital care, and the discharge, if applicable, during the hospitalization for the delivery.

If a physician or CNM is preparing to deliver a baby and it is decided that the baby must be delivered by an emergency C-section and an OB must be called in, then the following applies:

- The physician or certified midwife may receive payment from Medicaid for his or her involvement in the case by billing the C-section code with an 80 modifier, assistant surgeon. Technically, the physician or CNM would be billing as an assistant surgeon on the C-section. Reimbursement for this procedure is 20% of the C-section rate.

Multiple Births

Please refer to Multiple Births within the Billing Guidance section of this manual for the policy on billing for multiple babies.

Pre-Term Deliveries

Please refer to the “Abortion Guidelines” below for the policy on coding for a vaginal delivery or non-elective abortion.

Postpartum Care

Routine Postpartum Visit

The postpartum visit includes an uncomplicated routine GYN examination of the mother following a vaginal or C-section delivery. Only one postpartum exam per delivery is allowed. Reimbursement for all other routine postpartum visits is included in payment for the delivery.

Family Planning Counseling or instruction may not be billed in addition to the postpartum code when Family Planning services are rendered and documented. Please refer to Family Planning in this section of the manual for the code description and more details.

Complication/Other Medical Attention During 30-Days Post Delivery

If E&M services unrelated to routine postpartum care are necessary during the 30 days' post-delivery, bill these services using modifier 24. Documentation in the patient's chart should substantiate that the visit was unrelated to the delivery.

Note: Wound infection is not considered routine postpartum care.

Abortion Guidelines

Non-Elective Abortions

All non-elective abortions, including spontaneous, missed, incomplete, septic, hydatidiform mole, etc., require only that the medical record verify such a diagnosis. Medical procedures necessary to care for a patient with an ectopic pregnancy are not modified by this section and are compensable services.

Therapeutic Abortions

In compliance with federal regulations (42 CFR 441.203 and 441.206), SCDHHS requires documentation for all charges associated with instances of therapeutic abortion. This includes the attending physician, the anesthesiologist, and the hospital.

Therapeutic abortions are sponsored only in cases that a physician has found, and certified in writing to the Medicaid agency, that on the basis of his or her professional judgment, the pregnancy is the result of an act of rape or incest; or the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

The abortion statement must contain the name and address of the patient, the reason for the abortion, and the physician's signature and date. The patient's certification statement is only required in cases of rape or incest. The medical record must document that continued pregnancy would endanger the life of the mother or that the pregnancy is the result of an act of rape or incest. This may be reflected in the office admission history notes and physical, discharge summary, consultation reports, operative records and/or pathology reports. Both the abortion statement and the appropriate medical records must be submitted with the claim. A sample copy of the Abortion Statement Form can be found in the Forms section of the provider portal. If documentation is insufficient or the abortion statement is improperly completed, the claim will be rejected.

Questions should be directed to the PSC at: +1 888 289 0709 or providers should submit an online inquiry at: <http://www.scdhhs.gov/contact-us>.

Licensed Midwives

Medicaid sponsors the enrollment of licensed midwives. The scope of practice is limited to that defined in the South Carolina State Register, Volume 17, Issue 7, Chapter 61.

As Medicaid providers, licensed and certified midwives are required to maintain and disclose their records consistent with the Provider Administrative and Billing Manual. As allied health professionals, licensed midwives are required by State Law (SC Code Section 20-7-510) to report any signs of abuse or neglect to children that they may encounter in the office or home setting.

Additional enrollment and documentation requirements are specified below. For more information on Medicaid-sponsored midwifery services, please contact the PSC at: +1 888 289 0709 or submit an online inquiry at: <http://www.scdhhs.gov/contact-us>.

Requirements for Physician Back-up

The same physician or group must agree to provide the following services:

- Two assessment visits as required by regulations.
- Appropriate prescriptions for any medications that the midwife may administer at the time of the delivery according to the regulations (e.g., Pitocin, RhoGAM, eye prophylaxis, etc.).
- Medical evaluation and treatment in the event of a complication during pregnancy.
- Delivery services in the event of an emergency.

Birthing Centers

Medicaid will contract with birthing centers for obstetrical and newborn services. The birthing center must be licensed by SCDHEC prior to enrolling in the Medicaid program. For enrollment information, please contact our enrollment department at: +1 888 289 0709.

OB/Newborn Care with Technical Component (TC) Modifier

Medicaid will reimburse for an all-inclusive facility fee. The facility fee will include all technical services provided by the birthing center including, but not limited to, administration, nursing, drugs, surgical dressings, supplies and materials for anesthesia.

Observation for Maternity/Labor

This service is billable for observation of maternity/labor. This code is billable only if the patient is at the birthing center laboring but the labor does not progress and the patient is sent home to return at a later time or discharged to the hospital.

Pulse Oximetry Policy

SCDHHS accepts the SCDHEC Pulse Oximetry Screening test on newborns to detect congenital heart defects. Pulse oximetry is a non-invasive test that estimates the percentage of hemoglobin in blood that is saturated with oxygen.

The “Emerson Rose Act” (Act) became effective September 11, 2013, mandating that SCDHEC require each birthing facility it licenses to perform a pulse oximetry screening test, or other SCDHEC approved screening to detect critical congenital heart defects, on every newborn in its care. A newborn may be exempt from the required screening if the parent of the newborn objects, in writing, for reasons pertaining to religious beliefs only.

In accordance with the Act, birthing facilities shall perform a pulse oximetry screening test, or other SCDHEC approved screening to detect critical congenital heart defects, on every newborn when the baby is 24 to 48 hours of age, or as late as possible if the baby is discharged from the hospital before reaching 24 hours of age. Pulse oximetry screening for newborns shall be performed in the manner designated by SCDHEC guidelines located at <https://www.scdhec.gov/>. The hospital reimbursement for newborns is an all-inclusive payment for services rendered during that hospital stay and thus includes the pulse oximetry screen.

In compliance with SCDHEC policy, licensed midwives and certified nurse midwives that deliver a newborn in a birthing center must also perform this test. In addition, SCDHHS requires the test to be performed when a newborn is delivered in place of service home. When billing SCDHHS for the screening:

- Licensed midwives delivering in a birthing center or home must bill the appropriate code appended with the SB modifier.
- Certified nurse midwives or other clinician delivering in place of service birthing center or home must bill the appropriate code appended with a UD modifier, Medicaid level of care 13, as defined by each state.

The birthing center is responsible for following the policy as outlined by SCDHEC. Medicaid reimbursement for this procedure will be paid at the line level.

Levonorgestrel-Releasing Intrauterine System (Mirena®) Coverage

Medicaid will sponsor reimbursement for the Levonorgestrel-Releasing Intrauterine System (Mirena®). To bill for Mirena®, the provider may use the appropriate HCPCS J code. Please include the FP modifier on the claim form. Providers should continue to use the appropriate Family Planning diagnosis codes and CPT codes for the insertion and removal of the device.

Etonogestrel Implant (Implanon®) Coverage

Medicaid will sponsor reimbursement for the Etonogestrel Implant (Implanon®/Nexplanon®), a single-rod implantable contraceptive that is effective for up to three years. To bill for Implanon®/Nexplanon®, the provider may use the appropriate HCPCS J code. Please include the FP modifier on the claim form. Providers should continue to use the appropriate Family Planning diagnosis codes and CPT codes for the insertion and removal of the device.

Zithromax (Oral Suspension)

Medicaid will sponsor reimbursement for Zithromax (Azithromycin) for oral suspension in one-gram dose packets by prescription or when provided in the physician's office. An appropriate code may be used when this oral drug is provided in the physician's office.

Lupron Depot® (Leuprolide Acetate)

Medicaid will sponsor reimbursement for Lupron Depot® injections. The provider must supply the drug; no prior authorization is required.

Pessary

Medicaid will sponsor reimbursement for pessaries; the physician must provide the pessary.

Salpingectomy and/or Oophorectomy

The operative report must be submitted with the claim. The medical record must reflect medical necessity for the procedure performed. Reimbursement using these codes is not allowed if performed as a sterilization procedure, unless a copy of the Sterilization Consent Form is attached. A sample copy of the form can be found in the Forms section of the provider portal.

Depo-Provera for Other than Contraceptive Purposes

An appropriate code is used to report Depo-Provera for other than contraceptive purposes. Dosage is 50 mg. Frequency is limited to 500 mg and should be billed in units of 50 mg.

Family Planning Program

See Family Planning within this section of the manual for more information.

Elective Sterilization

SCDHHS is required to have a completed Sterilization Consent Form that meets the federal regulations for all charges associated with elective sterilization. Photocopies are accepted if legible. The physician should submit a properly completed consent form with his or her claim so that other providers involved with the sterilization procedure may also be reimbursed.

Definitions (as stated in the Code of Federal Regulations 42 CFR 441.251)

Sterilization — Any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Institutionalized Individual — An individual who is:

- Involuntarily confined or detained under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or
- Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

Mentally Incompetent Individual — Means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

All sections of the Sterilization Consent Form (DHHS Form 687) must be completed when submitted with the claim for payment. Each Sterilization Claim and Consent Form are reviewed for compliance with federal regulations (42 CFR 441.250–441.259 subpart F).

Requirements

For Medicaid financial coverage of an elective sterilization for a male or female, the following requirements must be met:

- The Sterilization Consent Form must be signed at least 30 days prior to, but no more than 180 days prior to, the scheduled date of sterilization.
- The individual must be 21 years old at the time the consent form is signed.
- The individual cannot be institutionalized or mentally incompetent. If the physician questions the mental competency of the individual, he or she should contact the PSC at: +1 888 289 0709 or submit an online inquiry at: <http://www.scdhhs.gov/contact-us>.
- The individual must voluntarily give consent. All questions must be answered and all topics in the consent form discussed. (A witness of the patient's choice may be present during the consent interview.) The Family Planning Counseling or family planning education/instruction procedure code may be billed when this service is rendered and documented.
- A copy of the consent form must be given to the patient after Parts I, II, and III are completed.
- At least 30 days, but not more than 180 days, must have passed between the signing of the consent form and the date of the sterilization procedure. The date of the beneficiary's signature is not included in the 30 days (e.g., day one begins the day after the signature). No one can sign the form for the individual.

Exceptions to the 30-day waiting period are:

- **Premature Delivery** — The informed consent must have been signed at least 30 days prior to the expected date of delivery. In cases involving a C-section, the scheduled date of the C-section is considered the expected date of delivery. At least 72 hours must have elapsed since the informed consent was given.
- **Emergency Abdominal Surgery** — The emergency does not include the operation to sterilize the patient. At least 72 hours must have elapsed since the informed consent was given. An explanation must accompany the consent form.

Note: If the beneficiary is pregnant, premature delivery is the only exception to the 30-day waiting period.

Informed consent may not be obtained while the patient to be sterilized is:

- In labor or childbirth.
- Seeking or obtaining an abortion.
- Under the influence of alcohol or other substances which may affect the patient's judgment.

Specialty Care Services

This section of the manual contains policies and guidelines for services that are primarily performed and billed by specialty physicians who treat specific body systems. However, all physicians are subject to all guidelines in this manual.

Consultations

A consultation is a request for an opinion and/or advice only. A consultation may involve a complete or a single organ system examination, followed by a written report in the patient's medical record.

The attending physician makes the request and continues in the role of primary physician unless he releases the patient to the consultant. The request for a consultation must be documented in the patient's record. The date the attending physician turns the patient's care over to the consultant should be documented, and the initial physician ceases billing.

When the consultant assumes responsibility or management of a portion or all of the patient's condition, services are considered subsequent hospital visits, office visits or concurrent care.

A follow-up consultation involves the consultant's re-evaluation of a patient on whom he or she has previously rendered an opinion or advice. As in initial consultations, the consultant provides no patient management or treatment.

Coverage — Consultation may be covered when the following conditions are met:

- A consultation or follow-up consultation is requested from a physician whose specialty or sub-specialty is different from the attending physician, for the opinion and/or advice in the further evaluation or management of the patient.
- Multiple consultations for the same patient must be determined to be medically necessary. Each consultation should relate to a different diagnosis or document that unusual circumstances exist, such as severity of condition or complexity of care.

Initial Inpatient Consultation — Using the CPT guidelines for terminology and levels of service, one initial consultation is allowed per patient per admission.

Follow-up Inpatient Consultation — After an initial consultation, a maximum of two follow-up consults may be billed using the CPT guidelines.

Documentation must reflect the request for the follow-up consultation and indicate that the consulting physician has not assumed responsibility for any portion of the patient's care. The third follow-up visit and all subsequent visits during that hospitalization must be billed with subsequent hospital visit codes.

Office or Other OP Consultations — Use the CPT guidelines for terminology and levels of service.

Referral

A referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. Use proper codes for initiation of treatment (i.e., office or hospital visit codes).

Psychiatric and Counseling Services

Psychiatric services include E&M, psychotherapy, and other services to an individual, family, or group and are compensable when medically indicated and in compliance with Medicaid policies. In order to be covered under the Medicaid program, a service must be medically necessary. Medical necessity means the need for treatment services is necessary to diagnose, treat, cure, or prevent an illness, or participation in services is expected to relieve pain, improve and preserve health, or be essential to life. Medicaid eligible beneficiaries may receive psychiatric and psychotherapy services when there is a confirmed psychiatric diagnosis from the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) or the ICD. Any psychiatric services provided to a child less than three years of age should be carefully documented to show medical necessity.

Covered psychiatric and psychotherapy services include the following:

- Psychiatric diagnostic evaluation
- Environmental intervention for medical management
- Psychological testing
- Psychotherapy
- Family Psychotherapy with patient present
- Family Psychotherapy without patient present
- Group psychotherapy
- Psychotherapy for crisis
- Medical E&M

These services are provided to, or directed exclusively toward, the treatment of the Medicaid-eligible beneficiary for the purpose of ameliorating disabilities, improving the beneficiary's ability to function independently, and restoring maximum functioning.

Please refer to Covered Services in this manual for appropriate codes for each covered service listed above and who is eligible to bill for these services.

Frequency Limits

With the exception of the psychiatric diagnostic evaluation, psychiatric and psychotherapy services are not included in the 12 ambulatory visit limit for beneficiaries age 21 and older. Please refer to Ambulatory Care Visit Guidelines within section 3 of this manual for further information on the ambulatory visit limit.

Eligible Medicaid beneficiaries ages 21 and older will be allowed 12 mental health visits per fiscal year (beginning July 1st through June 30th of each year) without prior authorization. Please note that services counted in the mental health visit count are psychotherapy, family psychotherapy and group psychotherapy. E&M codes without a psychotherapy add-on code will not be included in the 12 mental health visit limit. Please refer to Covered Services in this manual for details. Beneficiaries under age 21 are exempt from this limitation.

Referral to Allied Professionals

The psychiatric diagnostic evaluation completed by the physician/NP (also referred to as the supervising clinician) shall result in a determination of the beneficiary's need for psychiatric services and/or psychotherapy services. The physician/NP must document all treatment services authorized

to be provided to the beneficiary. If appropriate, the physician/NP may authorize services to be rendered by an allied professional. The physician/NP must:

- See each beneficiary initially unless the beneficiary was accepted as a referral from another physician.
- Authorize the treatment services to be provided by the allied professional.
- Participate in patient staffing with the allied professional to document progress summaries.

If the beneficiary is referred by a non-physician (e.g., DSS, school counselor, etc.), the referral source must be documented in the chart.

When scheduling is a problem or the beneficiary's condition requires immediate treatment, a maximum of two psychotherapy visits in 14 days will be allowed by an allied professional under supervision prior to an initial psychiatric diagnostic evaluation by the supervising clinician. The supervising clinician must then perform the initial psychiatric diagnostic evaluation before any further psychotherapy services can be provided.

In all cases, the supervising clinician must assume all professional liability for services rendered by staff under his or her supervision. In the event of a post-payment review, the supervising clinician who is reimbursed by Medicaid is responsible for all records. Credentials of allied professionals who provided services must be on file and will be part of the post-payment review. If the allied professional's credentials are not on file or do not meet the qualifications, the supervising clinician's payments will be subject to recoupment.

Supervision

Direct supervision in the physician's office, group practice or clinic setting means that the supervising clinician must be responsible for all services rendered and be accessible at all times during the diagnosis and treatment of the beneficiary.

Services provided under direct supervision are covered only if the following conditions are met:

- The allied professional must be a part-time, full-time, or contracted employee of the supervising clinician, physician group practice, or of the legal entity that employs the supervising clinician; or the allied professional must be an independent contractor engaged by the physician/NP through a written agreement.
- The supervising clinician cannot be employed by the allied professional.
- The supervising clinician must be accessible to the allied professional while services are being delivered and must meet with the allied professional at a minimum of every 90 days to review beneficiary progress.

- The service must be furnished in connection with a covered physician/NP service that was billed to SCDHHS; therefore, the beneficiary must be one who has been seen by the physician/NP.
- A psychiatric diagnostic evaluation has to be performed by the supervising clinician.

The allied professional providing psychotherapy personally works with the beneficiary to develop the IPOC and the supervising clinician meets with the beneficiary periodically during the course of treatment to monitor the service being delivered and to review the need for continued services. There must be subsequent services by the supervising clinician of a frequency that reflects his/her continued participation in the management of the course of treatment. The supervising clinician assumes professional responsibility and liability for all services provided by allied professionals.

The supervising clinician must spend as much time as necessary directly supervising the services to ensure that patients are receiving services in a safe and efficient manner in accordance with accepted standards of practice. The supervising clinician must meet with the allied professional and document the monitoring of performance, consultation, guidance and education at a minimum of every 90 days to ensure the delivery of medically necessary services.

A supervising clinician is limited to supervising no more than three allied professionals who meet the qualifications to render psychotherapy services. Prior to services being rendered by allied professionals, the names and credentials of the three allied professionals being supervised must be submitted to:

SCDHHS

Division of Behavioral Health

Post Office Box 8206

Columbia, SC 29202-8206

Fax: +1 803 255 8204

This information must be updated as necessary or at least every 12 months. To satisfy this requirement, complete and return a copy of the Allied Professional Supervision Form found in the Forms section of the provider portal. Additionally, the credentials of the allied professionals must be maintained on file at the office where services are being provided.

Individualized Plan of Care (IPOC)

If it is determined through the psychiatric diagnostic evaluation that a beneficiary needs psychotherapy services and a referral is made to an allied professional OR psychotherapy services will be provided by the physician/NP, an IPOC is required within 45 days of the date of the initial psychiatric diagnostic evaluation. The IPOC is an individualized, comprehensive treatment plan, which is based on the assessment and is created in partnership with the beneficiary and/or legally responsible person, except in the case of an emergency. The IPOC is designed to improve and/or stabilize the beneficiary's condition and should encompass all treatment goals and objectives.

The following services are not required to be listed on the IPOC:

- Psychiatric diagnostic evaluation
- Psychotherapy for crisis
- Environmental intervention
- E&M
- Psychological testing

Services not outlined in the treatment plan, other than those listed above, are non-billable and subject to recoupment. The allied professional providing psychotherapy services under the supervision of a physician/NP may develop the IPOC, but the IPOC must be signed by both the allied professional and the supervising clinician when psychotherapy is being provided by an allied professional.

The IPOC provides the overall direction for the treatment of the beneficiary and must include the following elements:

- Individualized treatment goals developed in conjunction with the beneficiary and/or family.
- Specific interventions and strategies that will be used to meet goals.
- Outcomes that are anticipated to be achieved by provision of the service and projected date of achievement.
- A projected schedule for service delivery, including the expected frequency and duration of each treatment method.
- The beneficiary and/or legally responsible person must sign the IPOC indicating that they were involved in the planning process and were offered a copy of the IPOC. If the beneficiary does not sign the IPOC, the reason must be documented in the clinical record.
- The physician/NP's signature is required on the IPOC to confirm the diagnosis, medical necessity of the treatment, and the appropriateness of care.

The original IPOC supervising clinician's signature date stands as the date to be used for all subsequent progress summaries, reviews and reformulations. Each page of the IPOC must be signed, titled and signature dated by the supervising clinician. Services added or frequencies of services changed in an existing IPOC must be signed and dated by the supervising clinician. An updated copy must be provided to the beneficiary. The IPOC must be filed in the beneficiary's clinical record with any supporting clinical documentation.

Progress Summary

A progress summary is a periodic evaluation and review of the beneficiary's progress toward the treatment goals, the appropriateness of the services being provided, and the need for the beneficiary's continued participation in treatment. If psychotherapy services are being provided by an allied professional, the supervising clinician and allied professional must meet to review the beneficiary's participation in all services every 90 days with completion during the calendar month in which it is due. Reviews may be conducted more frequently if the nature of needed services changes or if there is a change in the beneficiary's condition or status as determined by the physician/NP.

Progress summaries shall be documented in detail in the beneficiary's record and include:

- The beneficiary's progress towards treatment goals.
- The appropriateness of the services provided and their frequency.
- The need for continued treatment.
- Recommendations for continued services.
- The signature and title of the supervising clinician and allied professional.

If it is determined during the progress summary that the IPOC needs to be modified, then an updated IPOC also must be developed.

IPOC Reformulation

The maximum duration of an IPOC is 12 months (365 days) from the date of the signature of the supervising clinician. The allied professional must evaluate with the beneficiary his/her progress in reference to each of the treatment goals and desired outcomes. Based on the progress of the beneficiary, the IPOC should be reformulated annually to include updated treatment goals and outcomes. The signature of the supervising clinician is required on the reformulated IPOC.

Transition/Discharge

The supervising clinician is responsible for determining the duration of treatment based on the individual needs of the beneficiary. The allied professional involved in the delivery of services to the beneficiary may gather and/or give information to assist with this process. Beneficiaries should be discharged from treatment when they meet one of the following criteria:

- Level of functioning has significantly improved with respect to goals outlined in treatment plan.
- All treatment goals have been achieved.
- Beneficiary has developed skills and resources needed to transition to a lower level of care.

- Beneficiary requests discharge (and is not imminently dangerous to self or others).
- Beneficiary requires a higher level of care (e.g., inpatient hospitalization or Psychiatric Residential Treatment Facility [PRTF]).

Psychiatric Diagnostic Evaluation

Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

Psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

- Psychiatric diagnostic evaluation
- Psychiatric diagnostic evaluation with medical services

These procedures may be reported once every six months and not on the same day as an E&M service performed by the same individual for the same beneficiary.

Note: These procedures are included in the ambulatory visit limit.

Eligible to bill: Physician/Psychiatrist or Psychiatric NP

Psychological Testing

Psychological Testing Psychological testing includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI, Rorschach, WAIS) per hour of the physician's time, both face-to-face time administering tests to the beneficiary and time interpreting these test results and preparing the report.

- Psychological testing.
- Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.
- Each additional hour is listed separately in addition to code for primary procedure.

These procedures are reimbursed per hour, not per test. Report time as face-to-face time with patient and the time spent interpreting and preparing the report. Only three hours are allowable per day with a maximum limit of 12 hours in one year.

Note: This procedure is not included in the mental health visit limit.

Eligible to bill: Physician/Psychiatrist or Psychiatric NP

Environmental Intervention for Medical Management

Environmental intervention for medical management purposes on a psychiatric patient's behalf, including coordination of services. This code can be billed when the supervising clinician meets with an allied professional to coordinate services, discusses treatment issues, and review the treatment plan for a beneficiary and must be clearly documented in the progress summary and signed by the supervising clinician. This code cannot be billed each time the clinician signs the chart only. One progress summary is required every 90 days. Medicaid will reimburse only the supervising clinician for this service.

- Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.

This procedure is reimbursed in 30-minute increments (units), not to exceed an hour and a half per day. The supervising clinician, when coordinating services with allied professionals, may bill one unit of this code.

Note: This procedure is not included in the mental health visit limit.

Eligible to bill: Physician/Psychiatrist or Psychiatric NP

Psychotherapy

Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified healthcare professional, through definitive therapeutic communication, addresses the emotional disturbance, reverses or changes maladaptive patterns of behavior, and encourages personality growth and development. Psychotherapy times are for face-to-face services with beneficiary and/or family member. The beneficiary must be present for all or some of the service.

- Psychotherapy, 30 minutes
- Psychotherapy, 45 minutes
- Psychotherapy, 60 minutes

One session, regardless of time, is allowed per day within this range of procedures. If this service is being billed, an IPOC must have been completed for the beneficiary.

Note: These procedures are included in the mental health visit limit.

Eligible to bill: Physician/Psychiatrist, Psychiatric NP or LMSW — with HO Modifier

Psychotherapy with Medical Evaluation and Management Services

Some psychiatric patients receive a medical E&M service on the same day as a psychotherapy service by the same physician/NP. To report both E&M and psychotherapy, the two services must be significant and separately identifiable. Please refer to the current CPT for further instruction. These services are reported by using the following codes specific for psychotherapy when performed with E&M services as add-on codes to the E&M service:

- Psychotherapy, 30 minutes
- Psychotherapy, 45 minutes
- Psychotherapy, 60 minutes

One session, regardless of time, is allowed per day within this range of codes. If this service is being billed, an IPOC must have been completed for the beneficiary.

Note: These procedures are included in the mental health visit limit.

Eligible to bill: Physician/Psychiatrist or Psychiatric NP

Family Psychotherapy

Family psychotherapy is a face-to-face intervention with family members of the beneficiary with the purpose of treating the beneficiary's condition and improving the interaction between the beneficiary and family member(s) so that the beneficiary may be restored to their best possible functional level. Family Psychotherapy may be rendered with or without the beneficiary to family members of the identified beneficiary as long as the identified beneficiary is the focus of the sessions. The identified beneficiary is the family member with the symptom that has brought the family into treatment. Only issues pertinent to the identified beneficiary may be addressed under this service.

- Family Psychotherapy including patient, 50 minutes
- Family Psychotherapy, 50 minutes

One session, regardless of time, is allowed per day within this range of codes. If this service is being billed, an IPOC must have been completed for the beneficiary.

Note: These procedures are included in the mental health visit limit.

Eligible to bill: Physician/Psychiatrist, Psychiatric NP or LMSW — with HO Modifier

Group Psychotherapy

Group psychotherapy is a face-to-face intervention with a group of beneficiaries who are addressing similar issues with the purpose of restoring the beneficiary to his/her best possible functional level. Therapy is conducted in small groups. The group must be a part of an active treatment plan and the goals of group therapy must match the overall treatment plan for the individual beneficiary. The focus of the therapy sessions must not be exclusively educational or supportive in nature. Groups must consist of one professional and no more than eight beneficiaries.

- Group Psychotherapy — other than of a multiple-family group.

This code is covered for eligible beneficiaries in a group, even when the whole group is not Medicaid eligible. Medicaid will reimburse a clinician for one group session per day per Medicaid-eligible beneficiary. If this service is being billed, an IPOC must have been completed for the beneficiary.

Note: This procedure is included in the mental health visit limit.

Eligible to bill: Physician/Psychiatrist, Psychiatric NP or LMSW — with HO Modifier

Psychotherapy for Crisis

Psychotherapy for Crisis is an urgent assessment and history of a crisis state, a mental status exam and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a beneficiary in high distress.

- Psychotherapy for Crisis — This procedure is used to report the first 30–74 minutes of psychotherapy for crisis on a given date. It should be used only once per date even if the time spent by the physician or other qualified health care professional is not continuous on that date. The beneficiary must be present for all or some of the service.
- A separate code is used in conjunction with Psychotherapy for Crisis to report each additional 30 minutes of crisis for psychotherapy.

Note: These procedures do not count toward the mental health visit limit.

Eligible to bill: Physician/Psychiatrist, Psychiatric NP or LMSW — with HO Modifier

Medical Evaluation and Management Services

Some psychiatry services may be reported with Medical E&M services or other services when performed. E&M services may be reported for treatment of psychiatric conditions, rather than using Psychiatry Services codes, when appropriate. Please refer to the current CPT as E&M codes are classified by type of service, place of service and the patient's status.

Eligible to bill: Physician/Psychiatrist or Psychiatric NP

Interactive Complexity

Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Please refer to the current CPT for complete definition. For billing purposes, this is an add-on code for interactive complexity to be reported in conjunction with codes for diagnostic psychiatric evaluation, psychotherapy, psychotherapy when performed with an E&M service and group psychotherapy.

Note: This procedure does not count toward the mental health visit limit.

Eligible to bill: Physician/Psychiatrist or Psychiatric NP

Ophthalmology and Optometry Services

SCDHHS recognizes parity between ophthalmologists and optometrists as defined by State Law with respect to reimbursement. Covered services for optometrists are based on SCDHHS policy and the South Carolina Labor and Licensing Board of Examiners in Optometry. For purposes of this policy, under the age of 21 represents all children from birth up to, but not including their 21st birthday. An adult is defined as an individual 21 years and older.

Routine vision services for beneficiaries 21 and over are non-covered services. Routine vision services are defined as services related to refractive care: routine eye exams, refractions, corrective lenses and glasses. Services related to disease of the eye are covered for an example glaucoma, conjunctivitis and cataracts.

Providers are responsible for billing codes that are within the scope of practice as defined by South Carolina Department of Labor and Licensing Regulatory Authority. When reporting services provided in an office, home, hospital or an institutional facility that are not specific ophthalmology codes providers must utilize E&M codes listed in the AMA CPT manual. Providers are responsible for all National Correct Coding Initiative (NCCI) rules and regulations.

If an E&M code is used for treatment of a disease, it cannot be used in conjunction with a comprehensive exam code for treatment on the same DOS (as defined by NCCI). The provider must bill either the E&M code or the comprehensive exam code. Providers must refer to the CPT manual to determine which E&M code is the most appropriate. The patients' record must reflect the level of service performed and must be well documented in the patients' chart. All services billed are subject to a PI review. During post-payment reviews (audits), auditors will monitor these codes closely to ensure that the code reflects the service billed and best meets the description reflected in the documentation. The use of E&M codes will count toward the 12 maximum visits allowed for all patients over the age of 21, for the fiscal year. The fiscal year begins July 1st of every year and ends June 30th of every year.

Part I — Vision Care Services

Vision care services are defined as those that are medically necessary for the diagnosis and treatment of conditions of the eye. Refractive care is defined as the exam and treatment of visual states such as, but not limited to, the correction of amblyopia, presbyopia and for all services that can be corrected by the provision of corrective lenses. Referrals from local DSS offices or staff, schools, and patient's actual complaints of visual acuity constitute justification to provide eye exams and other refractive services for children under the age of 21. Providers should note these referrals and complaints in the patients' medical records.

Exam and Glasses for Birth to Age 21

For the treatment of children under the age of 21, one complete comprehensive eye exam is covered within a 365-day period (12 consecutive months).

A complete set of glasses is provided every 365 days when medically necessary.

Repair and Replacement

Eyeglasses must be repaired without additional reimbursement when the repair or replacement of eyeglass parts is required due to defects in quality of materials or workmanship. Reimbursement is available for repair or replacement of eyeglass parts in situations where the damage is the result of causes other than defective materials or workmanship. Replacement parts should duplicate the original prescription and frame style. Repairs to frames may be rendered as necessary.

Providers should use the appropriate procedure code for the repair or replacement of component parts of eyeglasses. When a component part of eyeglasses is replaced, the U8 modifier should be affixed to the appropriate procedure code for the component part that is being replaced. The reason for the repair or replacement of parts must be documented in the recipients' records.

Replacement of a Complete Pair of Eyeglasses

Reimbursement is available for one complete pair of replacement eyeglasses that has been lost or destroyed within twelve consecutive months. The replacement for a complete pair of eyeglasses should duplicate the original prescription and frames. The U9 modifier is affixed to the appropriate procedure codes identifying fitting of eyeglasses and materials when claiming replacement of a complete pair of eyeglasses that has been lost or destroyed. An explanation of the circumstances surrounding replacement of the complete pair of eyeglasses must be maintained in the enrollee's record.

If a beneficiary has surgery or prescriptive change with a minimum of one-half diopter (0.50) during a 12 consecutive months, only replacement lenses (not frames) will be covered. Providers must document medical necessity in the patient's medical record.

Contact lenses are allowed when prescriptive glasses are medically unsuitable. Documentation must indicate the medical necessity for contact lenses over glasses.

Guidelines for Lenses and Frames

Fabrication of eyeglasses shall conform to the current American National Standards Institute prescription requirements, and all lenses, frames and frame parts must be guaranteed against defects in manufacture and assembly. The provider who receives reimbursement for dispensing the eyeglasses has the final responsibility for this guarantee.

When adjustments to eyeglasses are required, the adjustment must be made without additional reimbursement whenever the enrollee returns to the original dispenser.

If the enrollee selects frames or lenses that are not Medicaid reimbursable, the enrollee must be informed prior to the fabrication of the eyeglasses that he/she will be financially responsible. In such cases, Medicaid may not be billed for all or part of the cost of said frames or lenses.

Lenses

All lenses for children under the age of 21 are to be first quality impact resistant lenses meeting FDA regulations, free of surface imperfections such as pits, scratches or grayness. The lenses should not contain bubbles, striations or other surface abrasions.

Special Types of Lenses**Polycarbonate Lenses**

All lenses provided to beneficiaries up to the age of 21, must be polycarbonate lenses and billed with the appropriate HCPCS vision code; non-polycarbonate lenses are not covered by SCDHHS.

High-Index Lenses

A 10 diopters (10DS) or greater lens is reimbursable at acquisition cost that is documented by an itemized invoice when such cost is greater than the fee listed for the lens code in the fee schedule. The fee schedule can be found on the SCDHHS website: <http://www.scdhhs.gov/>.

Frames

Frames supplied are to be first quality frames. All frames must have eye size, bridge size, temple length and manufacturer's name or trademark imprinted on them.

If the enrollee returns to the original dispenser to obtain the service, future fittings must be made by that dispenser without additional reimbursement:

- Frame Complete
- Deluxe Frame

Guidelines for Contact Lenses

Daily wear contact lenses will be covered for beneficiaries under the age of 21, if medical necessity has been established and prescription glasses are not suitable for the beneficiary. Daily wear contact lenses will be supplied in monthly increments. Contact lens procedure codes are per lens

and the correct number of units should be indicated in the “units” column of the claim form/electronic record.

Providers must file for payment using the examination date as the DOS. Use CPT procedure codes for the fitting and dispensing of contact lens. These codes include the contact lens fitting, all follow-up visits, solutions and supplies. This reimbursement does not include the initial eye examination.

Special Requests

If the covered contacts do not meet the needs of the patient, providers can contact the PSC at: +1 888 289 0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us> before dispensing the contacts. Special requests will require medical justification prior to dispensing. The PSC will forward all requests to the Division of Health and Medical Services, which will review the requests and contact the provider with a decision. Health and Medical Services are responsible for all reviews and exceptions.

Covered Contact Lens Products

The following covered contact lens products includes:

- Contact lens, PMMA, spherical, per lens
- Contact lens, PMMA, toric or prism ballast, per lens
- Contact lens, gas permeable, spherical, per lens
- Contact lens, gas permeable, toric, and prism ballast per lens, or a high plus or minus gas permeable post cataract, per lens
- Contact lens, hydrophilic, spherical, per lens
- Contact lens, hydrophilic, toric or prism ballast, per lens
- UV lens, per lens
- Contact lens, other type. (Providers must contact and send documentation via the PSC. The PSC will forward the documentation to the Division of Health and Medical Services.)

Dispensing Codes for Contact Lenses and Glasses

The following dispensing codes and fees for contacts and glasses may be used when applicable for the services to be rendered.

92310 — Prescription of optical and physical characteristics of the fitting of contact lenses, with medical supervision of adaptation; corneal lenses. The dispensing procedure is bilateral and the fee listed is for both eyes.

92311 — Prescription of a corneal lens for aphakia. The dispensing procedure is unilateral and the fee listed is for one eye.

92312 — Prescription of corneal lenses for aphakia. The dispensing procedure is bilateral and the fee listed is for both eyes.

92313 — Prescription of a corneoscleral (large lens). The dispensing procedure is unilateral and the fee listed is for one eye.

92340 — Fitting of spectacles, except for aphakia. This code should only be filed when the glasses are physically received at the physician's office for the dispensing of glasses. The DOS when filing this procedure should always be the date the eye exam was performed.

92370 — Repair and refitting of spectacles; except for aphakia.

Optician

Providers should show eligible recipients the complete selection of Medicaid-reimbursable frames and explain that Medicaid pays only for frames that falls within the reimbursement limit.

Providers must have a selection of nickel-free frames for beneficiaries that have allergies to nickel. Providers must have a selection of oversized frames or special needs frames for children readily available as an option in the frame selection. See guidance above under Guidelines for Lenses and Frames.

Providers must file for payment using the examination date as the DOS. Reimbursement for eyewear does not include the initial eye examination. All records and medical justification must be documented and located in the patient's charts for auditing purposes.

Prescription requests must be written in language common to all health care practitioners providing vision care in the United States. Criteria for the prescription requests include, but are not limited to, the following:

- Unaided visual acuity at distance and near should be 20/30 or less. Aided and unaided visual acuities must be stated in the patient's records.
- Corrective lenses must be at least plus or minus 0.50 sphere or more, or plus or minus 0.50 cylinder or more in each eye; or 0.75 in one eye.
- Vertical and horizontal prisms will be authorized if medically necessary. The prescription must be remedial and not training — by nature.
- Replacement of lenses requires medical justification.

Self-Employed Optometrist

Reimbursement is provided for the following materials and services in accordance with the fee schedule:

- Complete optometric eye examination.
- Office-based E&M services, consultations, diagnostic examinations, and non-invasive procedures for the diagnosis and treatment of diseases of the eye and the prescribing of pharmaceutical agents authorized under State Law.
- Eyeglass lenses.
- Contact lenses.
- Repairs and refitting of eyeglasses.
- Fitting of eyeglasses.

Retail Optical Establishments and Ophthalmic Dispensers

Reimbursement is provided for the following materials and services in accordance with the fee schedule:

- Complete optometric eye examination (limited to retail optical establishments and ophthalmic dispensers who employ an optometrist).
- Office-based E&M services, consultations, diagnostic examinations and non-invasive procedures for the diagnosis and treatment of diseases of the eye and the prescribing of pharmaceutical agents authorized under State Law (limited to retail optical establishments and ophthalmic dispensers who employ and optometrist).
- Eyeglass lenses.
- Contact lenses.
- Repairs and refitting of eyeglasses.
- Fitting of eyeglasses.

The fee schedule for vision services is located on the SCDHHS website at: <http://www.scdhhs.gov/>.

Part II — Diagnostic Ophthalmology Services

Diagnostic services included in the CPT coding range 92018–92287 are compensable as separate procedures if performed as a distinct and individual service and not included in the ophthalmological or E&M exam, with the following restrictions:

Covered Services

Refractions

The determination of the refractive state is allowed as a separate procedure in addition to the ophthalmology exam.

Ophthalmoscopy

Routine ophthalmoscopy (direct or indirect) is a part of general and specific ophthalmologic services, whenever indicated. It is not reported separately. Ophthalmoscopy, extended, with retinal drawing, as for retinal detachment, melanoma, with interpretation and report, may be billed in addition to an ophthalmological exam or an E&M services procedure code. If medically necessary, this code may be billed one time per eye per DOS.

Visual Field Examination

This exam is compensable when medically indicated as separate from the ophthalmological or E&M exam.

Vision Therapy

The following procedures are allowed for vision therapy services only:

- Unlisted neurological or neuromuscular diagnostic procedure (Support documentation of therapy service must be attached to the claim.)
- Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report.
- Developmental testing; extended (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report.
- Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning, problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.

Note: If an eye examination indicates a need for corrective lenses, the examining provider performing the comprehensive exam must complete the course of treatment. This includes the eye examination and written prescription (Rx) for ordering the glasses for the Medicaid beneficiary.

Part III — Ocular Surgery

Post-Operative Management of Cataract Surgery

South Carolina Medicaid allows optometrists to bill for post-operative management only for appropriate CPT procedure codes. These are global codes and cover both the surgical care and post-operative management.

In order for an optometrist to bill and be reimbursed for post-operative management, optometrists must bill the above referenced codes using modifier 55 only. Ophthalmologists must bill the above referenced codes with modifier 54, surgical care only. If the ophthalmologist does not bill using a modifier, the provider will be reimbursed for the entire global fee, which includes both surgical care and post-operative management.

Ocular Prosthesis: The prescription and fitting of ocular prostheses are covered for all eligible beneficiaries. The molding and manufacturing of the actual prosthesis is through our Agent, MUSC Maxillofacial Prosthodontic Clinic. Providers must contact MUSC Maxillofacial Prosthodontic Clinic at:

Phone Number: +1 843 876 1001

Fax Number: +1 843 876 1098

Providers are responsible for forwarding all medically necessary documentation to our Agent in order for services to be rendered.

Intraocular Lenses: Physicians who supply these lenses may bill using the codes listed below. The codes are for the supply of lenses and should be billed in addition to the surgical procedure.

- Anterior chamber angle fixation lens.
- Posterior chamber lens.

Ptosis: Lid correction procedures are covered only when there is documented medical necessity for the improvement of visual disabilities. Services must be preauthorized by Keystone Peer Review Organization, Inc. (KEPRO), the Quality Improvement Organization (QIO) contractor, for utilization review.

Note: Simple blepharoplasty is considered a cosmetic procedure and therefore non-compensable.

Keratoplasty: Corneal transplants are compensable. Physician reimbursement includes only the surgery. Reimbursement to the hospital includes all technical services including donor preparation.

Special Ophthalmological Services

The following medical ophthalmology codes may be billed separately from an ophthalmology exam or an E&M services code. These codes may be billed one time per eye per DOS when medically necessary.

- Ophthalmoscopy, extended, with retinal drawing, as for retinal detachment, melanoma with interpretation and report; initial.
- Ophthalmoscopy, extended; subsequent.
- Fluorescein angiography with interpretation and report.
- Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral.
- Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral.
- Ophthalmodynamometry.
- Electrooculography with interpretation and report.
- Electroretinography with interpretation and report.
- External ocular photography with interpretation and report for documentation of medical progress.
- Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count.
- Special anterior photography with fluorescein angiography.

Use of Modifiers with Procedure Codes

If it is medically necessary to repeat an ophthalmology procedure on the same DOS and the procedure is bilateral (i.e., the procedure is for both eyes), then the total charge amount for both eyes must be listed on the first line and again on the line recording the repeated procedure.

In order for the claim to process, the modifier on the first line must be “00” (two zeros), and the modifier on the line recording the repeated procedure must be (76). This is the only time these two modifiers should be used. It is imperative that the medical record of this patient indicates and justifies the medical necessity of repeating this service on the same day. The use of two modifiers indicates that the procedure was done bilaterally on the first occurrence and again bilaterally on the second occurrence. Indicate a “1” in the “units column” for the number of units on each line.

When medically necessary to repeat the same procedure on the same DOS and the procedure is unilateral, then the total charge amount for one eye must be listed on the first line utilizing an RT, right side (used to identify procedures performed on the right side of the body) or LT modifier, left side (used to identify procedures performed on the left side of the body). The second line for the repeated procedure should be billed utilizing a 76 modifier. The medical record of the patient must indicate and justify the medical necessity for the repeat procedure.

Reminder: In all cases, the fee listed for all ophthalmological procedures is for both eyes, unless otherwise indicated.

The use of modifiers AP (determination of refractive state was not performed in the course of diagnostic ophthalmological examination) is not reimbursed by SCDHHS and will result in rejected claims.

The following modifiers should be used for replacement of parts:

U8 = Replacement of a part of frames

U9 = Replacement of a part

Otorhinolaryngology (ENT)

General ENT Services

Diagnostic or treatment procedures usually included in an ENT exam are reported as an integrated medical service and should not be reported separately.

Microsurgical Techniques are procedures that describe “microsurgical techniques requiring use of operating microscope.” It can be billed in addition to the primary surgical procedure if it is not an inclusive part of the surgical procedure and if the documentation supports the use of microsurgical techniques. It is not for visualization of the operative field alone, but is intended to be employed when the surgical services are performed using the techniques of microsurgery.

If the use of the operating microscope is an inclusive component of a procedure, the use of the operating microscope cannot be unbundled. The CMS does not pay separately for services that should be paid together.

Endoscopic Procedures: Please refer to guidelines for endoscopic procedures under General Surgery Guidelines in this section of the manual.

Uvulopalatopharyngoplasty: Documentation (admission history and physical and operative report) is required with claims submitted for this procedure. The record must substantiate medical necessity as well as clarify the procedures performed.

Septoplasty, Turbinectomy: These and any other nasal reconstructive surgeries are covered only when there is a loss or serious impairment of bodily function, usually as a result of trauma, and the surgery restores the disabled function. The office record must document the functional deficit or the need for prompt correction.

Speech Therapy (ST) and Hearing Therapy Services

Services rendered by ENT specialists or therapists supervised by a physician are compensable using the appropriate code in the CPT with the following restrictions:

- ST and Hearing Therapy: Non-compensable. Please refer to Specialized Speech and Hearing Services for Children Under 21 below regarding services for children.
- Vestibular Function Test without Recording: Non-compensable (included in visit code).
- Ear Protector Attenuation Measurements (ear plugs): Non-compensable.
- Hearing Aids and Hearing Aid Accessories: Must be pre-authorized and obtained through the SCDHEC. Services are limited to children under age 21. For prior approval, send request to:

Division of Children's Rehabilitative Services
Box 101106, Mills Complex
Columbia, SC 29211
+1 803 898 0784

- Ear Molds: To report, physicians must use the following supplemental codes:
 - Ear mold, not disposable, any type.
 - Ear mold, disposable, any type.
 - Use modifiers RT (right side) and LT (left side) to indicate which ear.
 - These codes are allowed four times every 12 months per ear for children under age 21.
- Cochlear Device Implantation: Requires prior approval from KEPRO one of the following methods:

KEPRO Customer Service: +1 855 326 5219
KEPRO Fax: +1 855 300 0082

- Specialized Speech and Hearing Services for Children Under 21: Services are available through clinics certified by SCDHEC and through individual speech language pathologists/audiologists who are licensed by the South Carolina State Board of Examiners in Speech-Language Pathology and Audiology and enrolled with the South Carolina Medicaid program.

Speech/language and audiology services rendered by these providers must be pre-authorized by SCDHEC, South Carolina Department of Disabilities and Special Needs, or a school district. ENT specialists who provide these specialized services in their office or clinic may apply for certification. If certified by SCDHEC, the physician must enroll as a speech and hearing clinic with South Carolina Medicaid in order to obtain payment for these services (for children under 21). For information on SCDHEC certification requirements, you may write to:

Department of Health and Environmental Control
Clinic Certification
2600 Bull Street
Columbia, SC 29201

Cardiology

Physicians performing these services in their office may bill for the complete procedure code, which includes the tracing, interpretation and report. Those providers interpreting the recording only must use the code that stipulates interpretation and report only. The modifier 26 is not necessary when the code clearly defines the professional component only (interpretation and/or report).

For more detail regarding EKG interpretations, please refer to Radiology Reimbursement Limitations under Radiology and Nuclear Medicine in this section of the manual.

Pulmonary Medicine

Oxygen therapy given in the office is compensable when medically indicated and clearly identifiable as a separate procedure. Documentation must be submitted with the claim.

Questions regarding oxygen therapy equipment for home use should be directed to the PSC at: +1 888 289 0709. Providers may also submit an online inquiry at <http://www.scdhhs.gov/contact-us> for additional information.

A separate code is used to report tracheostomy tube change in the office setting. This may be used in addition to the appropriate level office E&M visit codes.

Overnight sleep apnea study services should be billed using the appropriate code.

Tuberculosis (TB) Policy

TB services cover treatment directly related to the care of TB which falls under the following categories:

- Prescribed medications
- Physician services
- OP hospital services

- Public health clinics
- Laboratory
- Radiology
- Case management

Note: This policy does not cover hospital stays, room and board or observation stays.

Treatment of a beneficiary with TB is most successful within a comprehensive framework that addresses both clinical and social issues of relevance to the beneficiary. It is essential that treatment be tailored and supervised based on each beneficiary's individual clinical and social needs (patient-centered care). SCDHEC is ultimately responsible for ensuring that adequate, appropriate diagnostic and treatment services are available, and for monitoring the results of therapy.

Initial TB Screening

The initial TB screening will be covered when performed by a NP, PA or Registered Nurse employed by the SCDHEC clinic. The initial screening includes, but is not limited to the following:

- Brief mental and physical assessment
- Exposure history
- Referral for laboratory testing and or radiology services
- Referral for social services
- Referral for other medical services
- Consultation with TB medical clinician

SCDHEC will bill SCDHHS for an E&M code.

For beneficiaries that are not in the limited benefits category (Family Planning and/or TB only), SCDHEC will provide a referral for the beneficiary to be seen by a physician if medically necessary and maintained in the beneficiary's medical health record. The physician must bill SCDHHS utilizing a new patient examination 99203 CPT code. The physician will be reimbursed for the initial consultation as long as the consultation is done within a 30-day period from the date of the initial TB screening service provided by SCDHEC, or all initial and subsequent treatment will be denied. If SCDHEC determines that it is medically necessary for the beneficiary to see a physician for subsequent visits, they are responsible for providing authorization, which must be maintained in the

beneficiary's medical health records. All services are subject to audit by SCDHHS Division of Program Integrity.

Subsequent Nursing Services

Subsequent nursing services are covered services when performed by an NP, Registered Nurse, and Licensed Practical Nurse, in the SCDHEC clinic or home setting. SCDHEC must bill all medically necessary exams to SCDHHS utilizing the appropriate E&M code. The maximum number of visits allowed for a treatment cycle is 360 for a beneficiary with latent TB infection and 360 for a beneficiary with TB disease. Medical necessity must be maintained within the beneficiary's medical health records.

Case Management

All Case Management services will be patient-centered and will include an adherence plan that emphasizes DOT, in which a beneficiary is observed to ingest each dose of anti-TB medications, to maximize the likelihood of completion of therapy. Each beneficiary's management plan must be individualized to incorporate strategies that facilitate adherence to the treatment regimen. Such measures may include, for example, social service support, treatment incentives and enablers, housing assistance, referral for treatment of substance abuse, and coordination of the TB services with those of other providers.

SCDHEC is responsible for providing all Case Management services. Case Management services include, but are not limited to:

- Medication monitoring
- Providing services in the patient's home
- Referring all medically necessary laboratory tests
- Referring all medically necessary radiology tests
- Referring patient to a physician for consultation when medically necessary

Case Management services are limited to 360 visits per year, one visit per day. Case Management services will be covered when performed by a NP, PA, Registered Nurse or Social Worker employed by the SCDHEC clinic.

Multidrug-Resistant Tuberculosis (MDR-TB) Treatment Protocol

MDR-TB is a form of TB that is resistant to two or more of the primary drugs (isoniazid and rifampin) used for the treatment of TB. The MDR-TB patient treatment model may involve a step approach. First high-dose oral medications are used that may include drugs such as isoniazid, pyrazinamide and ethambutol. Then treatment can move to injectable drugs, such as capreomycin, kanamycin and amikacin. Treatment length may be extended to manage the disease.

The use of this very intense treatment regimen also requires that the MDR-TB patient receive additional services. For these patients the below additional procedures codes are covered. For all services provider should follow NCCI correct coding.

- Vision screens up to six times per year
- Labs
- Peripherally inserted central catheter (PICC) line insertion

Pharmacotherapy

All treatment medications will be provided by SCDHEC for SCDHEC patients who have been diagnosed with TB disease and/or latent TB infection regardless of enrollment status (FFS or TB-only eligible). All medications will be reimbursed via 340B pricing. SCDHEC must submit the acquisition cost plus dispensing fee to SCDHHS. SCDHHS will then reimburse SCDHEC for the TB medications submitted.

Laboratory Tests

All laboratory tests are subject to medical necessity guidelines and documentation must be maintained in the beneficiary's chart.

Laboratory tests should be billed with a "00" (two zeros) modifier. If the laboratory tests are referred to an outside laboratory, then SCDHEC will provide authorization which will be maintained in the beneficiary's medical health records.

Radiology Tests

Radiology tests including interpretation of exams are covered if performed by a NP, PA or Physician:

All radiology procedures must be billed with the appropriate modifiers. See below for a list of modifiers and descriptions:

- Modifier 00 must be appended to the CPT code when the provider has rendered both the TC (the physical taking of an x-ray) and the professional component (interpretation of results).
- Modifier TC must be appended to the CPT code when the provider has only rendered the taking of the x-ray.
- Modifier 26 must be appended to the CPT code when the provider has rendered the interpretation only. Providers are required to write a report and sign, and date.

Allergy and Immunotherapy

Allergy Testing

Scratch testing is the gold standard for Allergy Testing and is a covered service. Beneficiaries should be instructed not to take antihistamines for three days prior to testing in order to insure accurate results. Allergy testing under anesthesia and RAST testing is not a covered service. Allergy testing for food allergies is not normally considered medically necessary. Therefore, if the provider is testing for food allergies, they must clearly state the medical necessity and supporting documentation in the beneficiary's medical record. All services are subject to audit through the SCDHHS Division of Program Integrity.

Allergen Immunotherapy

Allergen Immunotherapy is performed by providing injections of pertinent allergens to the patient on a regular basis with the goal of reducing the signs and symptoms of an allergic reaction or prevention of future anaphylaxis. This is usually done with allergen dosages that gradually increased over a period of months.

Providers may bill for professional services for allergen immunotherapy not including provision of allergenic extracts. These codes are for professional services only and do not cover reimbursement for antigen extract or venom.

Antigen and Preparation

Refer to code information on the provider portal for information on covered services.

Allergy Testing and Immunotherapy

Allergy Testing

The MPFSDB fee amounts for allergy testing services are established for single tests. Therefore, the number of tests must be shown on the claim.

Example: If a physician performs 25 percutaneous tests (scratch, puncture or prick) with allergenic extract, the physician must bill the appropriate code and specify 25 in the "units" field of form CMS-1500 (paper claims or electronic format). To compute payment, the Medicare carrier multiplies the payment for one test (i.e., the payment listed in the fee schedule) by the quantity listed in the "units" field.

Allergy Immunotherapy

For services rendered on or after January 1, 1995, all antigen/allergy immunotherapy services are paid for under the Medicare physician fee schedule. Prior to that date, only the antigen injection services, were paid for under the fee schedule. Codes representing antigens and their preparation and single codes representing both the antigens and their injection were paid for under the Medicare reasonable charge system. A legislative change brought all of these services under the fee schedule at the beginning of 1995 and the following policies are effective as of January 1, 1995:

- Separate coding for injection-only codes and/or the codes representing antigens and their preparation must be used.
 - If both services are provided, both codes are billed.
 - This includes allergists who provide both services through the use of treatment boards.
- Single dose vials of antigen should be billed only if the physician providing the antigen is providing it to be injected by some other entity. Single dose vials, which should be used only as a means of insuring proper dosage amounts for injections, are costlier than multiple dose vials and therefore their payment rate is higher. Allergists who prepare antigens are assumed to be able to administer proper doses from the less costly multiple dose vials. Thus, regardless of whether they use or bill for single or multiple dose vials at the same time that they are billing for an injection service, they are paid at the multiple dose vial rate.
- The fee schedule amounts for the antigen codes are for a single dose. When billing those codes, physicians are to specify the number of doses provided. When making payment, carriers multiply the fee schedule amount by the number of doses specified in the “units” field.
- If a patient's doses are adjusted, e.g., because of patient reaction, and the antigen provided is actually more or fewer doses than originally anticipated, the physician is to make no change in the number of doses for which he or she bills. The number of doses anticipated at the time of the antigen preparation is the number of doses to be billed. This is consistent with the notes on page 30 of the Spring 1994 issue of the AMA's CPT Assistant. Those notes indicate that the antigen codes mean that the physician is to identify the number of doses “prospectively planned to be provided”. The physician is to “identify the number of doses scheduled when the vial is provided”. This means that in cases where the patient actually gets more doses than originally anticipated (because dose amounts were decreased during treatment) and in cases where the patient gets fewer doses (because dose amounts were increased), no change is to be made in the billing. In the first case, carriers are not to pay more because the number of doses provided in the original vial(s) increased. In the second case, carriers are not to seek recoupment (if carriers have already made payment) because the number of doses is less than originally planned. This is the case for both venom and non-venom antigen codes.
- Venom doses and catch-up billing — Venom doses are prepared in separate vials and not mixed together — except in the case of the three vespid mix (white and yellow hornets and yellow jackets). Separate codes should be used for venom combinations of 2, 3, 4 or 5 venoms. Some amount of each of the venoms must be provided. Questions arise when the administration of these venoms does not remain synchronized because of dosage adjustments due to patient reaction. For example, a physician prepares ten doses utilizing the four venom code in two vials — one containing 10 doses of three vespid mix and another containing 10 doses of wasp venom. Because of dose adjustment, the three vespid mix doses last longer, i.e., they last for

15 doses. Consequently, questions arise regarding the amount of "replacement" wasp venom antigen that should be prepared and how it should be billed. Medicare pricing amounts have savings built into the use of the higher venom codes. Therefore, if a patient is in two venom, three venom, four venom or five venom therapy, the carrier objective is to pay at the highest venom level possible. This means that, to the greatest extent possible, the two venom code is to be billed for a patient in two venom therapy, the three venom code is to be billed for a patient in three venom therapy, the four venom code is to be billed for a patient in four venom therapy, and five venom code is to be billed for a patient in five venom therapy. Thus, physicians are to be instructed that the venom antigen preparation, after dose adjustment, must be done in a manner that, as soon as possible, synchronizes the preparation back to the highest venom code possible. In the above example, the physician should prepare and bill for only five doses of "replacement" wasp venom — billing five doses of the single venom code. This will permit the physician to get back to preparing the four venoms at one time and therefore billing the doses of the "cheaper" four venom code. Use of a code below the venom treatment number for the particular patient should occur only for the purpose of "catching up".

- Preparation of vials of non-venom antigens. As in the case of venoms, some non-venom antigens cannot be mixed together, i.e., they must be prepared in separate vials. An example of this is mold and pollen. Therefore, some patients will be injected at one time from one vial — containing in one mixture all of the appropriate antigens — while other patients will be injected at one time from more than one vial. In establishing the practice expense component for mixing a multi-dose vial of antigens, we observed that the most common practice was to prepare a 10 cc vial; we also observed that the most common use was to remove aliquots with a volume of 1 cc. Our PE computations were based on those facts. Therefore, a physician's removing 10 1 cc aliquot doses captures the entire PE component for the service.

This does not mean that the physician must remove 1 cc aliquot doses from a multi-dose vial. It means that the practice expenses payable for the preparation of a 10 cc vial remain the same irrespective of the size or number of aliquots removed from the vial. Therefore, a physician may not bill this vial preparation code for more than 10 doses per vial; paying more than 10 doses per multi-dose vial would significantly overpay the practice expense component attributable to this service.

Note: This code does not include the injection of antigen(s); injection of antigen(s) is separately billable.

When a multi-dose vial contains less than 10 cc, physicians should bill Medicare for the number of 1 cc aliquots that may be removed from the vial. That is, a physician may bill Medicare up to a maximum of 10 doses per multi-dose vial, but should bill Medicare for fewer than 10 doses per vial when there is less than 10 cc in the vial.

If it is medically necessary, physicians may bill Medicare for preparation of more than one multi-dose vial.

Examples:

- If a 10 cc multi-dose vial is filled to 6 cc with antigen, the physician may bill Medicare for six doses since six 1 cc aliquots may be removed from the vial.
 - If a 5 cc multi-dose vial is filled completely, the physician may bill Medicare for five doses for this vial.
 - If a physician removes $\frac{1}{2}$ cc aliquots from a 10 cc multi-dose vial for a total of 20 doses from one vial, he/she may only bill Medicare for 10 doses. Billing for more than 10 doses would mean that Medicare is overpaying for the practice expense of making the vial.
 - If a physician prepares two 10 cc multi-dose vials, he/she may bill Medicare for 20 doses. However, he/she may remove aliquots of any amount from those vials. For example, the physician may remove $\frac{1}{2}$ aliquots from one vial, and 1 cc aliquots from the other vial, but may bill no more than a total of 20 doses.
 - If a physician prepares a 20 cc multi-dose vial, he/she may bill Medicare for 20 doses, since the practice expense is calculated based on the physician's removing 1 cc aliquots from a vial. If a physician removes 2 cc aliquots from this vial, thus getting only 10 doses, he/she may nonetheless bill Medicare for 20 doses because the PE for 20 doses reflects the actual practice expense of preparing the vial.
 - If a physician prepares a 5 cc multi-dose vial, he may bill Medicare for five doses, based on the way that the practice expense component is calculated. However, if the physician removes ten $\frac{1}{2}$ cc aliquots from the vial, he/she may still bill only five doses because the practice expense of preparing the vial is the same, without regard to the number of additional doses that are removed from the vial.
- Allergy Shots and Visit Services on the Same Day:
 - At the outset of the physician fee schedule, the question was posed as to whether visits should be billed on the same day as an allergy injection, since these codes have status indicators of “A” rather than “T”. Visits should not be billed with allergy injection services unless the visit represents another separately identifiable service. This language parallels CPT editorial language that accompanies the allergen immunotherapy codes. Prior to January 1, 1995, you appeared to be enforcing this policy through three different means:
 - › Advising physician to use modifier 25 with the visit service,

- › Denying payment for the visit unless documentation has been provided, and
- › Paying for both the visit and the allergy shot if both are billed for.
 - » Provider must rely on the use of modifier 25 as the only means through which you can make payment for visit services provided on the same day as allergen immunotherapy services. In order for a physician to receive payment for a visit service provided on the same day that the physician also provides a service in the allergen immunotherapy series, the physician is to bill a modifier 25 with the visit code, indicating that the patient's condition required a significant, separately identifiable visit service above and beyond the allergen immunotherapy service provided.
- Reasonable Supply of Antigens:
 - See CMS Manual System, Internet Only Manual, Medicare Benefits Policy Manual, CMS Pub. 100-02 Chapter 15, section 50.4.4, regarding the coverage of antigens, including what constitutes a reasonable supply of antigens.
 - Providers should only bill Medicaid for a 90-day (three-month) supply of Antigens and/or Venoms for each Medicaid beneficiary. When the provider notices that the beneficiary is running low on antigens, he or she should arrange for more antigens to be made and delivered. Please note that these services cannot be over lapped and reimbursed.

Dermatology

The acne diagnosis codes (L70.0 - L70.9, L73.0) are covered only when the patient is 18 years of age or younger (non-covered beginning on the 19th birthday), and the acne condition is infected, cystic or pustular.

The keloid scar diagnosis L91.0 is covered only in severe cases with pain, intractable itching, or interference with range of movement.

Oncology and Hematology

If a physician or physician group leases space in a clinic or hospital, they may bill for the chemotherapy administration and drugs provided all the following criteria are met:

- They are using their own employees, equipment, supplies and drugs.
- The services are provided in the leased area of the hospital designated as an office.
- The patient is not a registered inpatient or OP of the hospital.

A physician's office within an institution must be confined to a separately identified part of the facility that is used solely as the physician's office and cannot be construed to extend throughout the entire institution. Services performed outside the "office" area will be subject to coverage rules applicable to services furnished outside the office setting.

A distinction must be made between the physician's office practice and the institution. For services to be covered, auxiliary medical staff must be office staff rather than institution staff, and the cost of supplies must represent an expense to the physician's office practice. The physician must directly supervise services performed by his or her employees outside the office area; the physician's presence in the facility as a whole would not be sufficient.

If services are provided in an inpatient, OP, or infusion center setting, the physician can only bill for the E&M service and/or prolonged care, critical care services when appropriate. Reimbursement for chemotherapy administration, drugs, supplies, equipment and nursing are included in the hospital or infusion center's reimbursement.

Breast Cancer Susceptibility Gene 1 and 2 (BRCA)

Definition

BRCA1 and BRCA2 genes encode for tumor suppressor proteins that function to preserve chromosome structure, repair damaged DNA, manage the cell cycle and transcription of DNA, and maintain the stability of genetic material.

Background

Individuals who inherit a mutated copy of the BRCA1 or BRCA2 gene are predisposed to developing breast, ovarian, tubal, peritoneal, pancreatic and prostate cancers. In rare cases, duplications or deletions of one or more exons, or coding regions, can occur and are classified as BRCA large cell rearrangements. Familial inheritance, of a mutated BRCA1 or BRCA2 gene, encompasses 5%–10% of all breast cancer cases. Screening and genetic testing is essential to identify individuals who have a family history of breast cancer and determine if they carry inherited mutations in BRCA1 or BRCA2 genes.

Coverage Guidelines

Criteria

The SCDHHS may cover BRCA genetic testing for eligible men and women who meet medical necessity criteria. Medical necessity criteria are based on the current National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology — Genetic/Familial High-Risk Assessment: Breast and Ovarian SCDHHS policy guidelines. To review the current NCCN guidelines you may visit:

https://www.nccn.org/professionals/physician_gls/pdf/genetics_screening.pdf

Meeting one or more of the breast and ovarian cancer criteria warrants further personalized risk assessment, genetic counseling and oftentimes, genetic testing and management. Testing of an individual without a cancer diagnosis should only be considered when an appropriate affected family member is unavailable for testing.

Age Requirements

Recipients of BRCA genetic testing must be 18 years of age or older. SCDHHS will not cover BRCA testing or associated genetic counseling for minors.

Genetic Counseling

Genetic counseling must be received before and after genetic testing for BRCA1, BRCA2 and BRCA large cell rearrangement. Pre- and post-genetic counseling are considered medically necessary, and is a covered service in addition to genetic testing. Genetic counseling is required to inform beneficiaries about the risks and benefits of genetic testing. Genetic counseling must be performed by an appropriately trained genetic counselor.

Genetic Testing

A blood test is performed on an individual to identify mutations in either of the two breast cancer susceptibility genes. The test will determine if an individual carries a mutated BRCA1 or BRCA2 gene.

Generally, genetic testing for a particular disease is limited to once in a lifetime; however, there may be exceptional instances that permit genetic testing more than once in a lifetime. SCDHHS will cover cases for additional BRCA testing for beneficiaries who:

- Have previously been tested for BRCA1 and BRCA2 comprehensive sequencing gene mutation analysis testing and received negative results. Documentation of negative results for BRCA1 and BRCA2 comprehensive sequencing gene mutation analysis is required for medically necessary BRCA large cell rearrangement gene mutation testing.
- Results are not available, and every reasonable attempt has been made to obtain the results. Documentation of reasonable attempts to obtain results from the genetic testing physician or the testing laboratory must be submitted to KEPRO when requesting prior authorization.

Cancer Risk-Reducing Interventions

The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal or peritoneal cancer or have an ethnicity or ancestry associated with BRCA1 or BRCA2 gene mutations with one of the several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling, and if indicated after counseling, BRCA genetic testing.

Based on the results of the BRCA test, beneficiaries may select a treatment that may reduce their chances of developing cancer. Medical necessity must be established for the selected risk reducing treatment option in accordance to the NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast and Ovarian. The specific guidelines may be accessed through this link:

https://www.nccn.org/professionals/physician_gls/pdf/genetics_screening.pdf

Note: Beneficiaries may also elect not to pursue treatment options.

Treatments include:

- Increased cancer screenings:
 - Cancer screenings may be received if a beneficiary does or does not desire risk-reducing therapy. Screening and follow-up options should be discussed between the beneficiary and their provider.
- Risk-reducing agent:
 - Risk-reducing agents may be covered for a beneficiary with a BRCA genetic mutation or compelling family history conferring a high-risk for breast, ovarian, tubal, peritoneal, pancreatic or prostate cancers.
- Risk-reducing surgery:
 - Risk-reducing prophylactic mastectomy or oophorectomy may be covered for a beneficiary with a BRCA genetic mutation or a compelling family history conferring a high risk for breast or ovarian cancer.

Gastroenterology

Diagnostic procedures listed are covered as separate procedures if medically necessary and justified.

Obesity is now recognized as a disease state. Policy is currently being written and will be published at a later date.

The following services are non-covered by Medicaid:

- Supplemental fasting
- Intestinal bypass surgery
- Gastric balloon for treatment of obesity

The following procedures to treat obesity are covered based on InterQual criteria. KEPRO must preauthorize all claims for these services. Approval will be based on medical records that document established InterQual criteria.

Panniculectomy

Panniculectomy is the surgical excision of the abdominal apron containing superficial fat in obese individuals. The Lipectomy and Abdominoplasty procedure codes can be covered by Medicaid if:

- It is medically appropriate and necessary for the individual to have such surgery.
- The surgery is performed to correct an illness caused by or aggravated by the pannus.

Gastrostomy Button Device Feeding Tube Kit

This service will be covered for beneficiaries under the age of 21 when performed in the physician's office setting to cover the cost associated with purchasing the device.

Physical Medicine and Therapy

PT, OT and/or ST may be rendered in an office, or OP setting. Licensed therapist performing these services must continue to meet the state licensure regulations specified by the South Carolina Department of Labor, Licensing, and Regulation (SCLLR). Licensed therapists may bill directly and be reimbursed for services rendered.

At a minimum, PT services must improve or restore physical functioning as well as prevent injury, impairments, functional limitations and disability following disease, injury or loss of limb or body part.

OT must prevent, improve, or restore physical and/or cognitive impairment following disease or injury.

Speech language pathology must improve or restore cognitive functioning, communication skills and/or swallowing skills following congenital or acquired disease or injury.

Physicians/NPs are required to submit the applicable CPT codes as defined in the CPT reference guide for the specified therapy. Therapy procedures are defined in 15 minute sessions, SCDHHS will define 15 minutes as one unit. Therapy sessions are limited to four units/one hour per DOS.

For children under the age of 21 PT/OT/ST services are available through rehabilitation centers certified by SCDHEC, and through individual licensed practitioners. Policy guidelines are located in the Private Rehabilitative Therapy and Audiological Services Provider Manual on our website located at: www.scdhhs.gov.

Osteopathic Manipulative Treatment

Osteopathic Manipulative Treatment (OMT) is allowed as a separate procedure when medically necessary, justified, and performed by a physician, or licensed physical therapist employed by the physician. These procedures should be reported using procedure codes 98925–98929.

Chiropractic Services

SCDHHS provides Medicaid reimbursement for a limited array of chiropractic services provided to Medicaid beneficiaries. Coverage is limited to treatment by means of manual manipulation of the spine for the purpose of correcting a subluxation demonstrated on x-ray. For the purposes of this program, “subluxation” means an incomplete dislocation, off centering, misalignment, fixation, or abnormal spacing of the vertebrae anatomically that is demonstrable on a radiographic film (x-ray).

It is the provider’s responsibility to ensure that services provided are due to medical necessity and are documented in the patient’s medical charts, and that the beneficiary’s Medicaid eligibility is current before chiropractic services are provided.

The provider should check the beneficiary’s Medicaid card before rendering services. Providers must call the toll-free number (+1 888 549 0820) listed on the back of the Medicaid insurance card to verify eligibility every time the Medicaid beneficiary is seen for chiropractic services. Eligibility changes on the first of each month. If services are provided, and are later denied because eligibility was not checked, Medicaid will not pay for the services and providers should not bill the patient for these services.

Eligible Medicaid beneficiaries, regardless of age, are allowed six chiropractic visits per year, commencing on July 1 of each year.

Neurology

Neurological testing procedure codes include the TC, interpretation, and the physician's professional services. Physicians doing only the interpretation must use the 26 modifier with the appropriate procedure code. All procedures must be medically justified.

Nerve Conduction Studies are covered as medically necessary when performed with needle electromyography (EMG) studies to confirm the diagnosis. It is recommended by the American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) that the nerve conduction study and a needle EMG be performed together to ensure an accurate diagnosis. Neurological testing includes the TC, the interpretation, and the physician's professional services. Physicians performing only the interpretation must use the 26 modifier with the appropriate procedure code.

Nerve conduction studies must be billed using CPT guidelines indicating each nerve and all site(s) along the nerve, not each site. Codes that indicate "each nerve" will multiply for payment, and must be submitted on one line with the number of tests (or hours) indicated in the “units” column on the claim form. Claims submitted with more than the allowed amount of units will reject with Edit

Code 713. Providers may submit a new claim with documentation for medical review. If justified, reimbursement may be made to the provider.

Hyperbaric Oxygen Therapy

For purposes of coverage, HBO therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

Covered Conditions

Program reimbursement for HBO therapy will be limited to that which is administered in a chamber (including the one-man unit) for the following conditions:

- Acute carbon monoxide intoxication.
- Decompression illness.
- Gas embolism.
- Gas gangrene.
- Acute traumatic peripheral ischemia. (HBO therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures, when loss of function, limb or life is threatened.)
- Crush injuries and suturing of severed limbs. (As in the previous conditions, HBO therapy would be an adjunctive treatment employed when loss of function, limb or life is threatened.)
- Meleney ulcers. (The use of HBO in any other types of cutaneous ulcer is not covered.)
- Acute peripheral arterial insufficiency.
- Preparation and preservation of compromised skin grafts.
- Chronic refractory osteomyelitis that is unresponsive to conventional medical and surgical management.
- Osteoradionecrosis as an adjunct to conventional treatment.
- Cyanide poisoning.
- Actinomycosis, but only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment.
- Soft tissue radionecrosis.

General Surgery Guidelines

Criteria outlined in this section are contingent upon demonstrated medical necessity. The medical record must substantiate the need for surgical services including information to support the medical justification. Compensable services include correcting conditions that meet any of the following criteria:

- Conditions that directly threaten the life of the beneficiary.
- Conditions that have the potential for causing irreparable physical damage.
- Conditions that can result in the loss or serious impairment of a bodily function.
- Conditions that can result in the impairment of normal physical growth and development.
- Conditions that result from trauma and must be promptly corrected (i.e., as soon as medically feasible).

When care is furnished outside of these conditions, documentation must be included in the medical record, or when designated, justification must be attached to the CMS-1500 claim form for payment. This includes the history and physical, operative report, discharge summary and pathology report.

If a claim is submitted that requires support documentation, and the required documentation is not attached to the claim form, the claim will be rejected. In this case, the documentation must be attached to a new claim for review.

Note: All unlisted procedure codes must have documentation attached to the claim form to ensure equitable pricing of the procedure.

To avoid delay in the processing of your claim, do not use an unlisted code when a descriptive code is available. All unlisted codes suspend for review and pricing.

If the reviewer finds a code comparable for the procedure, the unlisted code will be priced at the same rate as the descriptive code. The reviewer may also choose to notify the provider of the proper code to use for future reference.

Surgical Supplies

Please refer to Supplies under Additional Ambulatory Services in this section of the manual for more detail.

Ambulatory Surgical Services

Many surgical procedures ordinarily performed on an inpatient or OP basis consistent with sound medical practice can be performed in an Ambulatory Surgical Center (ASC) for less cost. South Carolina Medicaid recognizes these procedures as compensable if performed in an ASC and included on the ASC list of covered procedures.

Surgeons should utilize only those ASC facilities contracted with South Carolina Medicaid for their Medicaid patients. South Carolina Medicaid reimburses the ASC for the facility charges under strict guidelines. Each ASC contracted is provided with a list of covered procedures (which is subject to change from time to time).

Note: The surgeon should verify with the ASC that the elective procedure is covered under ASC guidelines.

Assistant Surgeon

All guidelines that apply to the primary surgeon also apply to the assistant surgeon. The CPT surgical procedure codes that allow an assistant surgeon's fee are listed on the provider portal.

Note: These allowances are subject to change and should be used as a reference only.

Surgical Guidelines for Specific Systems

Integumentary System

Lesion Removal

Excision/treatment of non-malignant dermal lesions and other dermal anomalies are not covered routinely. However, Medicaid will provide coverage of these anomalies if the therapy conforms with accepted treatment standards of the particular problem and meets one of the following conditions:

- The lesion is pre-cancerous or suspected to be cancerous by physical findings, appearance or changes in characteristics.
- The anomaly causes pain, irritation, or numbness that result in the functional impairment of bodily functions or normal growth and development.
- At least two alternative methods of treatment (i.e., steroid injection, compression, silicone gel treatment, etc.) have been attempted and found ineffective.
- The anomaly is responsible for the loss of a bodily function and the treatment restores the disabled function.

Keloid/Scar Conditions

Medicaid will provide coverage of excision and/or treatment of a Keloid scar and scar conditions and fibrosis of the skin if the therapy conforms to accepted standards of the particular problem and meets one of the following conditions:

- The scar causes functional impairment which interferes with daily living.
- The scar is symptomatic with a history of ulceration or inflammation that causes repeat office visits. At least two methods of treatment such as radiation (silicone gel treatment), compression, steroids and laser surgery have been tried and failed.
- There is a history of repeated infections with the scar.

Destruction Codes

Treatment must be medically indicated according to the criteria set forth in the guidelines previously stated. Certain procedures are considered cosmetic and therefore non-compensable.

Chemosurgery (Mohs Technique)

Procedures are compensable if medically justified and not performed for cosmetic purposes.

Mohs micrographic surgery is defined by the AMA's CPT as a technique for the removal of complex or ill-defined skin cancer with the histologic examination of 100% of the surgical margins. It requires a single physician to act in two integrated but separate and distinct capacities: surgeon and pathologist.

Musculoskeletal System

Facial Reconstructive Codes

Certain facial reconstructive procedures are covered. The criteria are contingent upon medical necessity as outlined in the General Surgery guidelines. Justification includes result of severe trauma and/or congenital malformations; each claim must have support documentation attached. If there is no documentation, the claim will be rejected.

If the reconstructive process must be performed in stages, each claim must have documentation that includes all prior stages. A consultant for the specialty will review each claim and make a determination.

Under no circumstances is payment allowed for reconstructive surgery performed for cosmetic reasons alone.

Fracture Repair (For Acute Care of an Injured Part)

All codes listed in the musculoskeletal section of the CPT are considered surgical packages with the exceptions of those listed in this manual.

The original application of a cast, splint, strapping, or traction device is included in the treatment of a fracture or dislocation and may not be billed separately.

Grafts

Most bone, cartilage and fascia graft procedures include the obtaining of the graft by the operating surgeon. When the assistant surgeon obtains the graft for the operating surgeon, the additional service may be identified and reported separately.

Casts

Application

The original application of a cast, splint, strapping or traction device is included in the treatment of a fracture or dislocation, and may not be billed separately except for the application of a halo type body cast, Risser jacket, turnbuckle jacket, body cast, or hip spica cast. Plaster or fiberglass can be billed additionally for cast supplies.

Plaster casts for rehabilitation are compensable using the appropriate CPT codes for the upper or lower extremity. Reimbursement includes the actual application of the cast. Supply codes may be billed in addition to the application.

Synthetic casts (fiberglass) are covered, but may only be billed one time during the patient's course of treatment. A delayed or non-union replacement or the replacement of a patellar-tendon-bearing (PTB) cast is covered.

Replacement

The application of a cast, splint, strapping or traction device is reimbursable if it is a replacement, or subsequent replacement to the original cast, splint, strapping or traction device.

Removal

Codes for cast removals are reimbursable only if another physician applied the cast.

Repair

To report any repairs made to a cast, use the supplemental codes plaster cast supplies, or fiberglass cast supplies.

Cast Codes

Cast codes will reimburse in an OP setting when the physician applies the cast. If these codes are applied by a hospital technician, then no reimbursement to the physician will be allowed.

Application or Strapping

If cast application or strapping is provided as an initial service (e.g., casting of a sprained ankle or knee) in which no other procedure or treatment (e.g., surgical repair, reduction of a fracture or joint dislocation) is performed, or is expected to be performed by a physician rendering the initial care only, use the casting, strapping, and/or supply code in addition to an E&M code, as appropriate.

Splints**Plaster Splints**

Plaster splints are compensable using the appropriate CPT codes for the upper or lower extremity. The reimbursement includes the materials used as well as the actual application of the splint.

Synthetic Splints

Synthetic splints (fiberglass) are covered, but may only be billed one time during the patient's course of treatment. Any replacement is non-covered and cannot be billed except a PTB, delayed, or non-union cast.

Custom Splints

Custom-made splints are recognized as a viable part in the patient's rehabilitative period of treatment. Reimbursement is allowed for these splints only when made by a licensed orthotist or occupational therapist. To report any repairs or adjustments made to a splint, use an appropriate supply code.

Prefab Splints

Prefabricated splints (Velcro closure) are non-compensable under the Physician Services program.

Orthotic Supplies

Please refer to the heading "Durable Medical Equipment/Supply" in this section of the manual.

Cardiovascular System**Vascular Injection Procedures**

Listed services for injection procedures include necessary local anesthesia, introduction of needles or catheters, injection of contrast medium with or without automatic power injection, and/or necessary pre- and post-injection care specifically related to the injection procedure. For injection procedures in conjunction with cardiac catheterization, please refer to Cardiology under Specialty Care Services in this section of the manual.

Radiological vascular injections performed by a single physician are compensable separate from the radiology service. Catheters, drugs and contrast media are not included in the listed service for these injection procedures.

For insertion of a Swan-Ganz catheter not associated with cardiac catheterization, use an appropriate assistant surgeon code in lieu of a heart catheter code.

Implantable Vascular Access Portal/Catheter

For port-a-cath maintenance, use the appropriate J codes, supply codes and office visit code when applicable. Do not use an unlisted CPT code for catheter maintenance.

Digestive System (et al.)

Contralateral Inguinal Exploration

Medicaid will reimburse for a contralateral inguinal exploration when a unilateral herniorrhaphy has been performed on an infant (under five years of age). To report this service, use an appropriate assistant surgeon code along with the procedure code for herniorrhaphy and attach support documentation for medical review.

Gastric Bypass

Please refer to Gastroenterology under Specialty Care Services in this section of the manual regarding treatment of obesity and bariatric surgical procedures.

Urinary System

Services listed in this section are covered when medically necessary, with the following restrictions:

- Endoscopic Procedures: Follow guidelines for endoscopic procedures under General Surgery Guidelines within this manual.
- Urodynamics: These procedures may be billed in addition to the appropriate surgical code (Cystourethroscopy); reimbursement includes equipment and supplies.
- When performed (and billed) on the same DOS as the surgery, these services are not considered surgical and will be reimbursed at 100% of the established rate. Documentation should include the urine measurement.
- Urinary Supplies: Please refer to the Durable Medical Equipment/Supply section of this manual.
- Lithotripsy: Percutaneous, extracorporeal shock wave, and cystourethroscope lithotripsy are covered services when medically necessary. The physician is reimbursed only for the professional service. If the procedure is performed bilaterally, bill on two lines adding no modifier to the first procedure, and a 50 modifier to the second (bilateral) procedure.

Nervous System

No special restrictions apply other than those defined in the general surgery and pain therapy guidelines.

Spinal Procedures for Injection of Anesthetic Substance

These procedures are reimbursed for the initial placement of an indwelling catheter for anesthesia purposes. Subsequent injections of the anesthetic agent are not allowed under the injection code. For maintenance of an epidural, please refer to Anesthesia Services and Pain Management Services in this section of the manual for additional information.

Implantable Infusion Pumps

An implantable infusion pump is covered when used to administer anti-spasmodic drugs intrathecally (e.g., Baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

- As indicated by at least a six-week trial, the patient cannot be maintained on non-invasive methods of spasm control.
- Prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of the anti-spasmodic drug.

Each claim will be reviewed for these criteria; claims submitted without documentation will be rejected.

Implantable infusion pumps are also covered for treatment of pain. Please refer to Pain Management Services in this section of the manual for additional information.

Organ Transplantation

See the Utilization Management, Prior Approval section of this manual for more information regarding organ transplants.

Anesthesia Services

Anesthesia services consist of services rendered by a physician, a CRNA, or anesthetist assistant (AA) other than the attending surgeon or his or her assistant, and shall include the administration of spinal or rectal anesthesia, or a drug, or other anesthetic agent. The agent may be administered by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation or loss of consciousness. The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician.

Use of the surgical procedure code for billing anesthesia services will result in a rejection. When multiple surgical procedures are performed during the same period of anesthesia, only the anesthesia procedure code for the major procedure should be billed and the total time should reflect coverage for all procedures. Base time associated with the procedure code will be automatically assigned from the procedure code billed.

There is no additional payment for anesthesia services rendered by the attending surgeon or assistant surgeon when performed on an inpatient or OP basis.

Time Reporting

Anesthesia time involves the continuous, actual presence of the anesthesiologist or the medically directed CRNA/AA. It starts when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room and ends when the anesthesiologist is no longer in continuous, actual attendance. See the Billing Guidance section of this manual for billing information.

Pain Management Services

The complaint of pain remains the single greatest reason for seeking medical attention. Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. The condition is considered chronic pain when it has been present continuously or intermittently for six months or more, or it has extended two to three months beyond the expected recovery time. It is of utmost importance that medical providers seek the source of the pain in addition to working to relieve and resolve the pain. Patient history must be reviewed to ensure all areas of treatment have been explored. Appropriate referrals for concurrent medical or psychological treatment must be made. This requires all physicians, not just pain specialists, to understand the pain symptoms and their underlying cause.

The primary objectives of pain management must be to accomplish the following:

- Eliminate the use of optional health care services for primary pain complaints.
- Increase physical activities and return the patient to productive activity.
- Increase the patient's ability to manage pain and related problems.
- Reduce the use and misuse of medication.
- Decrease the intensity of subjective or illusory pain.

The policies outlined in the remainder of the Pain Management Services section of this manual apply to physicians of all specialties.

Evaluation and Management Visits

Adult Medicaid beneficiaries (age 21 and older) have a limited number of ACVs each fiscal year. Please refer to Ambulatory Care Visit Guidelines in this section of the manual for additional guidance when billing for ambulatory visits for adults.

All covered ancillary services, including other diagnostic lab and x-ray services, are compensable. Surgical and diagnostic procedures, hospital care, and other medically necessary services are reimbursed regardless of the number of ambulatory visits used by the patient.

One office or inpatient consultation necessary for screening a beneficiary focusing on identifying the cause of the pain and developing a pain management plan will be covered. When the consultant

assumes responsibility for a portion or all of the patient's condition, appropriate office visit or subsequent hospital care codes should be used after the initial consultation. Consultative services related to any direct or indirect patient care are included in the basic value of an anesthesia payment and cannot be billed separately.

E&M guidelines apply to office, inpatient and OP hospital care for pain management.

External Infusion Pumps

The condition of external infusion pumps is covered for the following:

- Opioid drugs for intractable cancer pain.
- Treatment for acute iron poisoning or iron overload.
- Chemotherapy for liver cancer.
- Treatment for thromboembolic disease and/or pulmonary embolism.

Other uses of the external infusion pump may be reimbursable if the provider can document the medical necessity and appropriateness of this type of therapy and pump for the individual patient. Prior approval must be requested in writing for a condition other than those listed above.

Implantable Infusion Pumps

The use of implantable infusion pumps is covered for the following conditions:

- Chemotherapy treatment of liver cancer.
- Delivery of anti-spasmodic drugs for severe spasticity.
- Treatment of chronic intractable pain.

Chemotherapy for Liver Cancer

The implantable pump is covered for the treatment of liver cancer in patients in whom the metastases are limited to the liver, and where one of the following applies:

- The disease is unresponsive.
- The patient refuses surgical excision of the tumor.

Anti-Spasmodic Drugs for Severe Spasticity

An implantable infusion pump is covered when used to administer antispasmodic drugs intrathecally (e.g., Baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive therapy when both of the following criteria are met:

- As indicated by at least a six-week trial, the patient cannot be maintained on non-invasive methods of spasm control such as oral anti-spasmodic drugs, because these methods either fail to adequately control the spasticity, or they produce intolerable side effects.
- Prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of anti-spasmodic drug.

Treatment of Chronic Intractable Pain

An implantable pump is covered when used to administer opioid drugs (e.g., morphine) intrathecally or epidurally for the treatment of severe or chronic intractable pain in patients who have a life expectancy of at least three months, and who have proven unresponsive to less invasive medical therapy when ALL of the following criteria have been met:

- Coordination must be made with other attending physicians in order to identify and treat the cause of the pain, rather than symptoms, if at all possible.
- The patient's history must indicate that he or she would not respond adequately to non-invasive methods of pain control.
- A preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary catheter to monitor acceptable pain relief, degree of side effects and patient acceptance.

Refilling and maintenance of the implantable pump will be allowed when administered by a physician.

Determinations may be made on coverage of other uses for implantable infusion pumps if the provider can verify ALL of the following:

- The drug is reasonable and necessary for treatment of the individual patient.
- It is medically necessary that the drug be administered via an implantable infusion pump.
- The FDA-approved labeling for the pump specifies that the drug being administered and the purpose for its administration is an indicated use for the pump.

Pathology and Laboratory Services

In accordance with federal regulations (42 CFR 493.1809), all laboratory testing sites (except for physician's offices) are required to have an appropriate CLIA certificate. CLIA is a regulatory program administered by the CMS. For more detail, please refer to Clinical Laboratory Improvement Amendments within this section of the manual.

Pathology includes services rendered by attending physicians and pathologists. Hospital laboratories should reference the Hospital Services Provider Manual. Independent laboratories will be covered in this section.

Laboratory services/tests must be ordered by the attending physician, appropriate to the study of the patient (i.e., consistent with the diagnosis and treatment of the patient's condition and medically necessary for the appropriate care of the patient). Medicaid reimbursement will generally include obtaining the specimen, the performance of the test, supplies used in the performance of the test, and recording of the test(s). In addition, the reimbursement includes reporting of the test results.

The DOS for all billing must be the date the specimen was collected. For specimen collections that span more than a 24-month period, the DOS should be reported as the date the collection began. For laboratory tests that require a specimen from stored collections, the DOS should be defined as the date the specimen was obtained from archives. Procedures reimbursed in components will be identified later and separate allowable handling fees will be defined in this section.

Attending Physician Services

The attending physician is responsible for the study of the patient, medical necessity, and appropriateness of procedures ordered. Physicians may not bill for lab tests performed outside their offices. Physicians may not bill a patient for lab services performed in the office that are normally covered by Medicaid when the service would have been paid if a Medicaid claim was submitted, provided the physician has accepted the patient's Medicaid benefits for the office visit or other procedure on the same date.

The performance of a test(s) prior to seeing the patient is a screening procedure and is not compensable. The only exceptions are pregnancy tests and prenatal lab work.

All laboratory tests must be ordered for the appropriate diagnosis and treatment of the patient's illness. Laboratory services requested or performed as general screening services are non-compensable, with the exception of services rendered under the healthy adult physical as outlined in the Preventive Care Services section of this manual. General health panels are non-compensable; fertility tests are non-compensable. Routine paternity tests are non-covered, but medically necessary exceptions will be considered. Claims must be submitted with documentation justifying the service.

The chlamydia rapid test procedure code is used to report the chlamydia rapid test.

Venipuncture

A separate handling charge for blood products drawn through venipuncture is allowed and compensable. To report a routine venipuncture, use the collection of venous blood by venipuncture procedure code. Finger/heel/ear stick for collection of specimen(s) will be included in the office visit or lab test reimbursement and may not be billed separately. Filing for only the collection of

specimen(s) is permissible, but an office visit or lab test reimbursement charge cannot be filed for the same DOS. The physician or clinic provider may charge a separate venipuncture code if he or she provided the entire diagnostic lab service or only extracted the blood for referral to an outside lab.

Catheterization

Urine specimens collected by all methods are not considered a separate compensable charge. The patient is also not liable for the charge since the collection fee is considered part of the lab test or office examination. The provider may charge for a separate catheterization regardless of whether the specimen was collected for a test in the office or for referral to an outside laboratory.

Automated Chemistry Tests and Panels

Clinical laboratory tests are covered under Medicaid if they are reasonable and necessary for the diagnosis or treatment of an illness or injury. A physician who orders a series of clinical lab tests must specify the actual tests to be performed. If a panel is requested, the professional judgment of the physician must dictate the medical necessity of the complete panel instead of an individual test. Likewise, individual tests ordered by a physician must indicate a medical reason for the individual test in lieu of a panel that is less expensive.

Automated Multi-Channel Chemistry Tests

Refer the codes information on the provider portal for acceptable services. If three or more of the tests are performed on the same DOS, they will be grouped together and paid according to the number of tests performed. Duplicate payments and payments that are not consistent with Medicaid policy will be recouped at post-payment review.

Pathology Panels

Please refer to the current CPT for guidelines on acceptable criteria for billing organ or disease-oriented panels.

Clinical Pathology Services

South Carolina Medicaid will recognize both a professional and TC for all pathology codes. Refer to the codes information on the provider portal for pathology codes requiring a 26 modifier in a hospital setting.

Professional Pathology Services

Anatomical

Medicaid recognizes the expertise of professional pathology services when charged separately for the interpretation of all anatomical and surgical tissues. Postmortem examinations are non-covered by Medicaid.

Blood Smears, Bone Marrows and Blood Bank Services

The 26 modifier is not required when performed in a hospital setting.

Bone marrows, including smears, aspiration, staining, biopsy and interpretation, are compensable as separate professional services. Care should be taken when coding bone marrow interpretation procedures; the 26 modifier is not required.

Blood bank services are covered; no modifier is required when performed in a hospital setting.

Cytopathology and Surgical Pathology

These procedures include accession, handling and reporting. The handling and interpretation of surgical tissues must be charged separately if rendered by a pathologist in a hospital or office when only the professional interpretation is necessary, using a distinct physician provider number and a 26 modifier. Only an independent laboratory may charge for the total lab procedure when the laboratory has actually performed the total service (i.e., both technical and professional component related to the surgical tissue).

Some surgical pathology codes will multiply by units for payment. When filing a claim, list the appropriate CPT code for the DOS one time and the number of units in the “days/units” column and the total charges for the number of units billed. A frequency limitation of 10 units has been placed on these codes; services exceeding 10 units will require documentation.

Pap Smears

Medicaid reimburses a pathologist for a professional interpretation of a Pap smear. An attending physician must specifically order the appropriate cytopathology code with definite hormonal evaluation.

Medicaid covers Pap smears for dually eligible Medicare/Medicaid beneficiaries who have exceeded the Medicare frequency limit. When the Medicare denial is received, the charges should be billed using the CMS-1500 claim form. Please refer to Cancer Screening Services within this section of the manual for frequency limitations.

Specimen Referrals

The pathologist should use the appropriate procedure codes to designate review and report of referred material only. A separate procedure code is used for comprehensive consultation with review of medical records and specimens, with report, on referred material.

Referral Out-of-State (OOS)

Specimens must be referred to a South Carolina Medicaid-enrolled independent laboratory, pathologist or hospital. OOS referrals to non-enrolled providers are not compensable through the Medicaid program. Providers cannot bill Medicaid beneficiaries when Medicaid would have paid the lab service if appropriate billing and referral procedures had been followed.

Genetic Studies

Medicaid will reimburse for genetic studies if ordered by an attending physician and requested as a direct diagnosis and treatment tool. The genetic study may be ordered as a preventive measure; however, the prevention must have a direct correlation with the treatment of the patient and the patient's family, or serve as an inhibitor to institutionalization. Medicaid will not reimburse for genetic research.

Chromosome Analysis

Genetic centers are permitted to fragment chromosome charges into the "tissue culture for chromosome analysis" charge and the analysis charge. Chromosome studies must be medically necessary.

In addition, reimbursement may be allowed for the following expanded services: extended chromosome analysis, R-Bands, and Fragile X DNA analysis.

The following conditions may be used as indications of analysis:

- Intellectual disabilities
- Dysmorphic fractures
- Multiple congenital abnormalities
- Abnormal sexual development
- Abnormalities of growth
- Certain types of malignancies

Genetic Studies Also Covered by Medicaid**Lysosomal Enzyme Analysis for Developmental Regression (e.g., Tay-Sachs Disease)**

The following indications must be present:

- Growth failure
- Development regression
- Clouding of corneas
- Hepatosplenomegaly
- Coarsening of facial features

- Abnormalities of skeletal system

Amino Acid Analysis for Infants and Children

The following indications must be present:

- Feeding abnormalities
- Growth failure
- Development failure
- Seizures
- Uncommon acidosis

Organic Acid Analysis for Infants

The following indications must be present:

- Feeding abnormalities
- Unexplained acidosis
- Growth failure
- Seizures

Carbohydrate Analysis for infants and Children

One of the following indications must be present:

- Cataracts
- Hepatosplenomegaly
- Jaundice
- Growth failure
- Acidosis
- Seizures

Other Tests for Infants and Children

These tests include the following:

- Metabolic screen
- Alpha fetoprotein
- Sialic acid
- Sulfate incorporation

Amniocentesis for Prenatal Diagnosis

Allowable for the following categories of patient:

- Women over 35 years of age
- Previous child with chromosomal disorder
- Multiple spontaneous abortions
- Patients with neural tube defects
- Patients at risk for having children with X-linked disorder (i.e., hemophilia or Duchenne muscular dystrophy, or metabolic disorders such as Tay-Sachs disease)

Tests for the Detection of Other Genetic Diseases

These tests include the following:

- Skeletal Dysplasias
- Huntington's disease
- Sickle Cell
- Hemoglobinopathies

Radiology and Nuclear Medicine

Radiology services are those services performed by a radiologist/physician in conjunction with an x-ray, ultrasound, Positron Emission Tomography (PET scan), computerized axial tomogram (CAT scan), or magnetic resonance imaging (MRI). Radiological services are covered only when such services are consistent with the diagnosis and treatment of an illness or injury. Screening procedures are not reimbursable unless outlined as covered items in this manual.

Effective March 1, 2014, SCDHHS will no longer prior authorize high-tech radiology services. All radiology services will be based on medical necessity and held to the American College of Radiology (ACR) standards. ACR standards can be found at: <http://www.acr.org>.

This policy pertains to all FFS recipients and SCDHHS will no longer exclude anyone based on category or whether they have third-party liability primary coverage. Providers must continue to refer members in an MCO to the appropriate MCO provider in order to determine if prior authorization applies to radiology services.

Positron Emission Tomography (PET) Scans

PET scan reimbursement will be limited to two scans in a 12 consecutive month period. PET scans will only be covered for the staging and restaging of cancer malignances.

Staging

- The stage of the cancer remains in doubt after completion of a standard diagnostic work-up, including conventional imaging such as CAT scan, MRI or ultrasound, or
- The use of a PET scan could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient, and
- Clinical management of the patient would differ depending on the stage of the cancer identified.

Restaging

- Detecting residual disease.
- Detecting suspected recurrence or metastasis.
- Determining the extent of recurrence.
- Potentially replacing one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

PET scans will not be utilized for screening purposes and the use of PET scans to monitor tumor response during a planned course of treatment will not be covered. Restaging only occurs after a course of treatment is completed and 90 days has lapsed prior to the restaging PET scan. PET scans will be subject to retrospective review to include paid inpatient/OP hospital and physician claims. Documentation must be maintained in the beneficiary's medical records and must support medical necessity. SCDHHS will not cover any additional PET scans over the frequency limitation of two in a 12 consecutive month period.

Diagnostic Radiology

Medicaid requires that all facilities providing screening and diagnostic mammography services meet FDA regulations. Medicaid claims for mammography services will be reviewed to ensure FDA criteria are met. Medicaid will not reimburse for mammography services performed by providers who are not certified and providers cannot bill the Medicaid beneficiaries for the denied Medicaid services. An FDA certificate for screening mammography services must be in the provider enrollment file. Questions regarding enrollment should contact:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809
Phone: +1 888 289 0709

Diagnostic Ultrasound

Ultrasound procedures are recorded as complete, limited or repeat procedures. Full documentation must justify the use of the complete procedure code. A complete procedure is one that the provider furnished both the professional and TCs. Please refer to Obstetrics and Gynecology in this section of the manual for pregnancy-related guidelines.

Radiology Oncology

A preliminary evaluation/consultation of the patient is allowed prior to the decision to treat and should be identified by the appropriate E&M code. Once the therapist assumes responsibility for the treatment and care of the patient, a separate consultation or E&M code will not be covered.

Please refer to CPT reference manual for appropriate codes for the treatment planning, radiation physics, treatment delivery and treatment management of radiation oncology.

Clinical Treatment Planning

Please refer to the CPT reference manual for appropriate codes for the treatment and planning process. These services include test interpretation, tumor localization, treatment volume determination, time/dosage determination, treatment modality, number and size of ports and selection of treatment devices.

Medical Radiation Physics

Please refer to the CPT reference manual for appropriate codes for services by the physician and physicist involved in radiation physics, dosimetry calculation, construction of treatment devices and other special services.

Radiation Treatment Delivery

Radiation treatment codes reflect the technical portion of radiation therapy services. The codes will be found in your CPT reference manual and represent individual sessions of service delivery or daily services. Multiple treatment sessions on the same DOS are allowed as long as there is a distinct break in therapy services/individual session.

Clinical Treatment Management

Please refer to the CPT reference manual for appropriate codes. Clinical treatment management codes reflect the professional component of treatment on a weekly basis. These codes are used to describe the physician's weekly radiotherapy management services at all energy levels. A weekly unit is equal to five fractions or treatment sessions, regardless of whether the fraction or treatment sessions are furnished on consecutive days or without regard to the actual time period in which the services are provided.

Hyperthermia

Treatments include external and internal procedures. Hyperthermia is used only as an adjunct to radiation/chemotherapy. It may be initiated by microwave, ultrasound, low energy radio-frequency conduction or by probes.

Clinical Brachytherapy

Please refer to your CPT reference manual for all codes. Services bundled within the procedure codes include hospital admission, daily visits, follow-up care, dilation, insertion and removal of applicators. They do not include preparation of the element calculation of dosage, or loading of the element.

Nuclear Medicine

Please refer to the CPT reference manual for appropriate codes for services related to diagnostic and therapeutic nuclear medicine. The procedures may be performed and charged separately, or as part of a course of treatment. Radioimmunoassay tests are found in the Clinical Pathology section of the CPT reference manual.

Contrasts and Radiopharmaceuticals

For appropriate codes for billing contrasts and radiopharmaceuticals providers should refer to the HCPCS reference manual. Physicians must not bill for radiopharmaceuticals and/or contrasts that are provided by the hospital.

Independent Imaging Centers and Mobile Imaging Units

Independent Imaging Centers and Mobile Imaging Units: Medicaid will reimburse for services provided by a freestanding imaging centers, mobile ultrasound units, and mobile imaging units when the services are consistent with diagnosis, treatment, injury or covered preventative services as found in Family Planning.

Independent imaging centers, mobile ultrasound units and mobile imaging units can only be reimbursed for the technical portion of an x-ray or other imaging service. Separate reimbursement will be made to the physician for the professional interpretation of the radiology procedure. The physician's name must be on the radiology report as the reading/interpreting physician. Reimbursement will be sent to the reading/interpreting physician or reading/interpreting physician group practice. The reading/interpreting physician must be enrolled with SCDHHS as an in-state provider. All OOS providers must go through the OOS approval process. OOS physicians must attach a copy of the approval letter to each CMS-1500 form submitted for reimbursement.

Podiatry Services

Podiatry services are those services that are responsible and necessary for the diagnosis and treatment of foot conditions. These services are limited to the specialized care of the foot as outlined under the laws of the State of South Carolina.

Office Examinations

Level of service guidelines must be followed as described in the current CPT. Podiatric exams may be charged at all levels of services as medically necessary for new or established office E&M visits.

Treatment of Subluxation of the Foot

Subluxation of the foot is defined as partial dislocation to displacement of joint surfaces, tendons, ligaments or muscles of the foot.

Reasonable and necessary diagnosis and treatment (except by the use of orthopedic shoes or other supportive devices for the foot) of symptomatic conditions such as osteoarthritis, bursitis, tendonitis, etc., that result from or are associated with partial displacement of foot structures are covered services. Surgical correction of a subluxed foot structure that is either an integral part of the treatment of a foot injury, or that is undertaken to improve the function of the foot, or that is undertaken to alleviate an induced or associated symptomatic condition, is a covered service. The presentation of symptoms is clearly the paramount factor in coverage. Surgical and non-surgical treatments undertaken for the sole purpose of correcting the subluxed structure of the foot as an isolated entity are not covered.

Treatment of Flat Foot

The term "flat foot" is defined as a condition in which one or more of the arches of the foot have flattened out. Services directed toward the care or correction of such a condition is not covered. However, the services or procedures required to make the initial diagnosis may be considered reasonable and necessary and are covered.

Supportive Devices for the Feet

Orthopedic shoes and other supportive devices for the feet are not covered unless the shoe is an integral part of a leg brace.

Prosthetic Shoe

A prosthetic shoe (a device used when all or a substantial portion of the front part of the foot is missing) can be covered as a terminal device (i.e., a structural supplement replacing a totally or substantially absent foot). The beneficiary should be referred to a DME supplier for such devices.

Excision of Nail

When a procedure indicates a partial or total permanent nail removal, separate billing is not to be used for the medial and lateral borders of the same toe. The number of toes should be indicated if multiple toes are corrected at the same time.

Plantar Warts

Treatment for Verruca vulgaris and intractable plantar keratoma are covered services.

Mycotic Nail

Mycotic nail and other infections of the feet and toenails require professional services that are outside the scope of routine foot care and are covered services if the subsequent criteria are met. Treatment of a fungal (mycotic) infection of the toenail can be covered under the following circumstances:

- Clinical evidence of mycosis of the toenail.
- Medical documentation that the patient has either a limitation of ambulation requiring active treatment of the foot, or in the case of a non-ambulatory patient, a condition that is likely to result in significant medical complications in the absence of such treatment.

Routine Foot Care

Routine foot care includes the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventative maintenance care.

Reimbursement for routine foot care is allowed under the medical conditions listed below when the patient is under the active care of a physician and the service is provided by an osteopath or doctor of medicine. It is essential that the patient has seen a physician for treatment and/or evaluation of the complicating disease process during the six months prior to the DOS. The allowable conditions are as follows:

- Diabetes mellitus
- Chronic thrombophlebitis
- Peripheral neuropathies involving the feet associated with:
 - Malnutrition and vitamin deficiency

- Malnutrition (general, pellagra)
- Alcoholism
- Malabsorption (celiac disease, tropical sprue)
- Pernicious anemia
- Carcinoma
- Diabetes mellitus
- Drugs and toxins
- MS
- Uremia (chronic renal disease)

In evaluating whether the routine services can be reimbursed, a presumption of coverage is made where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis, and indicative of surface peripheral involvement.

The presumption of coverage is applied when a physician rendering the routine foot care has identified one Class A finding as noted below, two Class B findings, or one Class B and two Class C findings as follows:

Class A Findings:

- Non-traumatic amputation of the foot or an integral skeletal portion thereof

Class B Findings:

- Absent posterior tibial pulse
- Absent dorsalis pedis pulse
- A minimum of three trophic changes as follows:
 - Hair growth (decrease or absence)
 - Nail changes (thickening)
 - Pigmentary changes (discoloration)
 - Skin texture (thin, shiny)

- Skin color (rubor or redness)

Class C Findings:

- Claudication
- Temperature changes (e.g., cold feet)
- Edema
- Paresthesias (abnormal spontaneous sensations in the feet)
- Burning

Additional services ordinarily considered routine may also be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds and infections.

Nursing Home Visits

Podiatry care may be rendered to patients in nursing or rest home facilities, provided the service is medically necessary and meets the policies defined in this manual. Podiatry care must be requested by one of the following:

- The attending physician
- The patient
- The patient's family when the patient is incompetent
- Nursing service*
- Nursing service requests must be documented in the patient's chart. The podiatrist's records must indicate who made the request for services in this situation.

Federally Qualified Health Center Services

In 1992, the Healthcare Financing Administration (now CMS) issued Medicare regulation for the FQHC program. The FQHC laws established a set of health care services called "FQHC services" for which Medicare and/or Medicaid must cover on a reasonable cost basis when provided by an FQHC. For any questions concerning cost reports and cost settlements, please contact the PSC at: +1 888 289 0709 or submit an online inquiry at: <http://www.scdhhs.gov/contact-us>.

The subsections below outline a list of services referred to as FQHC core services. Core services are reimbursed using encounter codes.

Encounter Services

Currently the definition of a visit is a face-to-face encounter between an FQHC patient and a physician, PA, NP, CNM, chiropractor, clinical psychologist or clinical social worker, during which a Medicaid-covered FQHC core service is furnished. The South Carolina Medicaid program does not cover nutrition, health education, social work, or other related ancillary services unless noted in this section. For billing purposes, SCDHHS has deemed a “visit” as an “encounter”. Physicians and practitioners providing services under the FQHC program must meet the regular Medicaid enrollment requirements to provide services to Medicaid patients.

Only one encounter code is allowed per day, with the exception of the psychiatry and counseling encounter, which can be billed in addition to another encounter on the same day. FQHC services are covered when furnished to patients at the center, in a SNF, or at the client’s place of residence. Services provided to hospital patients, including ER services, are not considered FQHC services.

Physician Services

Physician services refer to the professional services (diagnosis, treatment, therapy, surgery and consultation) that a physician performs at the center.

Physician Assistant, Nurse Practitioner and Certified Nurse Midwife

PA, NP and CNM services refer to the professional services performed by one of these providers who:

- Is employed by or receives payment from the FQHC.
- Is under a physician’s general (or direct, if required by State Law) medical supervision.
- Provides services according to clinic policies or any physician’s medical orders for the care and treatment of the patient.
- Provides the type of services that a CNM, NP or PA is legally permitted by the State to perform.
- Provides the type of services that Medicare/Medicaid would cover if provided by a physician or incidental to physician services.

Clinical Psychologist and Clinical Social Worker Services

Clinical psychologist and clinical social worker services refer to professional services performed by one of these providers who:

- Is employed by or receives compensation from the FQHC.
- Provides services of any type that the professional is legally permitted to perform by the State in which the services are furnished.
- Provides the type of services that Medicaid would cover if furnished by a physician.

Services and Supplies

Supplies, lab work, injections, etc., are not billable services. These services and supply costs are included in the encounter rate when provided in the course of a physician, PA, NP, CNM, chiropractor, clinical psychologist and/or clinical social worker visit. The types of services and supplies included in the encounter are:

- Commonly provided in a physician's office.
- Commonly provided either without charge or included in the FQHC's bill (i.e., lab tests).
- Provided as incidental, although an integral part of the above provider's services.
- Provided under the physician's direct, personal supervision to the extent allowed under written center policies.
- Provided by a clinic employee.
- Not self-administered (drug, biological).

FQHC Adult Nutritional Counseling Program

This policy currently targets those obese individuals who do not meet the criteria for gastric bypass surgery or related services. Obesity is defined for this program as an adult patient with a BMI of 30 or greater.

Currently, this program will exclude the following categories of beneficiaries:

- Pregnant women.
- Patients, for whom medication use has significantly contributed to the beneficiary's obesity as determined by the treating physician, are not eligible to participate in the obesity program.
- Beneficiaries who have had or scheduled to have bariatric surgery/gastric banding/gastric sleeve.

- Beneficiaries actively being treated with gastric bypass surgery/vertical-banded gastroplasty/sleeve gastrectomy.

There is an exhaustive list of medications that could contribute to obesity. Here are examples of medications that may cause weight gain:

- Atypical antipsychotics (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone)
- Long-term use of oral corticosteroids (prednisone, prednisolone)
- Certain anticonvulsant medications (valproic acid, carbamazepine)
- Tricyclic antidepressants (amitriptyline)

Please note, for Healthy Connections Medicaid members also receiving Medicare benefits, SCDHHS will only pay secondary payments to Medicare.

The program consists of intensive behavioral therapy for obesity and includes three factors:

- Screening for obesity in adults using measurement of BMI calculated by dividing the patient's weight in kilograms by the square of height in meters.
- Dietary (nutritional) assessment.
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

The following billing instructions apply to FFS only. Providers who submit claims to a MCOs should refer to the provider contract with the appropriate MCO for billing instructions.

Provider

For this policy the word "provider" is defined as a physician, PA or NP who meets the licensure and educational requirements in South Carolina. All services must be within the SCMSA. SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

During the patient's routine physical exam or office visit, the provider will assess the patient's needs and whether he or she will benefit from participating in an obesity intervention program. The provider must bill utilizing the appropriate HCPCS encounter code. The provider must also bill the appropriate nutritional counseling HCPCS code with the South Carolina modifier. This is for tracking purposes only.

Remember, only one encounter code is allowed per day with the exception of psychiatry and counseling encounters, which can be billed in addition to other encounters on the same day.

All subsequent obesity visits must be billed utilizing the appropriate HCPCS encounter code. The provider must bill any nutritional counseling HCPCS code with a penny reimbursement in the charge field. The nutritional counseling HCPCS code is used for tracking purposes only. Subsequent visits may be billed as a one-on-one session between the provider and the patient or in a group setting. When billing for a group setting, the provider must append the HB modifier to the appropriate encounter code indicating that a group session has been rendered. All groups are limited to a maximum of five patients per group. The chart of valid codes and usages can be found on the provider portal.

All obesity visits must include the following components listed below:

- **Assess:** Ask about and assess behavioral health risk and factors affecting behavioral change goals/methods.
- **Advise:** Give clear, specific and personalized behavioral advice, including information about personal health, harms and benefits.
- **Agree:** Collaborate with the patient to select appropriate treatment goals and methods based on the patient's interest and willingness to change behavioral patterns and habits.
- **Assist:** Use behavioral change techniques (self-help and/or counseling) to aid the patient in achieving agreed upon goals by acquiring the skills, confidence, and social, environmental supports for behavioral change, supplemented with adjunctive medical treatments when appropriate.
- **Arrange:** Schedule follow-up contacts to provide ongoing assistance and or support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

The provider must also address the importance of exercise, developing a realistic exercise plan with goals. The obesity intervention plan must be documented in the patient's medical health record. The provider will arrange for an individual nutritional assessment to be provided by a licensed and Medicaid-enrolled dietitian within their facility.

The provider must schedule a follow-up exam with the patient to evaluate the progress he or she has made, reviewing compliance with the exercise plan and nutritional plan provided by the dietitian. Each time the provider sees the patient, he or she must clearly document the patient's progress, activities, and compliance with the treatment plan. The provider must record the patient's BMI in the chart.

The provider may perform all medically necessary diagnostic testing including but, not limited to A1C, cholesterol, triglycerides, T3, T4, TSH laboratory tests and EKGs. Reimbursements for lab work, supplies, injections, surgical procedures (unless noted under Special Clinic Services within this section of the manual), and other medical items are included in the encounter code.

All FFS beneficiaries age 21 and older are limited to 12 encounters per state fiscal year. If the patient has reached the maximum units allowed for the fiscal year, the provider may append a P4 modifier to the HCPCS encounter code and the service will be reimbursed.

Note: The P4 modifier should not be used to bypass the six provider visits and six nutritional encounters allowed for subsequent service in accordance with this obesity policy.

If the provider has determined that additional visits are medically necessary and the patient has complied with the program, the provider may request additional visits in accordance with the policy outlined under Additional Services within this section of the manual.

All service information must be written and maintained in the patient's medical record. All services are subject to review and recoupment by the Division of Program Integrity.

Dietitian

The dietitian is responsible for reviewing the patient's habits, providing education, reinforcing of the importance of exercise, developing a nutritional plan and establishing goals. The dietitian must document the patient's progress, activities and compliance with the nutritional and exercise plan. The dietitian must submit a written report to the ordering provider each time the patient is seen individually or in a group/class setting. The dietitian must maintain complete records of the nutritional plan, compliance and exercise plan in the patient's medical record.

The HCPCS encounter code encompasses both the provider's and dietitian's time and will be used for both the initial and follow-up encounters. Please note that the initial dietitian visit must be an individual one-on-one counseling session. In order for SCDHHS to track the dietitian visits, the FQHC must bill utilizing HCPCS code nutritional counseling, dietitian visit. When billing subsequent dietitian visits, the FQHC must bill S9452 (nutrition classes, non-physician provider) for tracking purposes. For all a group nutritional classes, the FQHC will append the HB modifier. All groups are limited to a maximum of five patients per group. All services for the provider and dietitian must occur on the same day utilizing one encounter.

Additional Services

If the provider has completed a series of six visits and the patient has been compliant with the treatment plan, and the provider has determined that the patient would benefit from additional treatment, the provider must submit documentation of medical necessity to the following address:

SCDHHS

Attention: Medical Director

PO Box 8206

Columbia, SC 29202

In order to receive additional visits not to exceed six additional provider visits and six additional nutritional counseling sessions within a 12-month period, the following documentation must be submitted by a physician, NP or PA only:

- A letter of medical necessity
- Patient notes
- BMI start and end
- A1C
- Dietitian reports
- Exercise plan and notes on adherence

All requests will be reviewed by SCDHHS Medical Directors for medical necessity and compliance with the obesity program.

FQHC Children's Nutritional Counseling Program

The following billing instructions apply to FFS only. Providers who submit claims to a MCOs should refer to the provider contract with the appropriate MCO for billing instructions.

FQHCs must follow all obesity policy guidelines listed under FFS Children's Nutritional Counseling Program within this section of the manual for both providers and dietitians. However, FQHCs must bill utilizing the HCPCS encounter code. The HCPCS code includes both the dietitian and the provider visit within one unit. FQHCs can only bill for individual obesity visits and cannot bill for group therapy visits under this policy. All documentation standards listed in the obesity policy apply.

Medicaid-eligible children under the age of 21 may receive unlimited E&M visits as long as the services are medically necessary. For this policy the word "provider" is defined as a physician, PA or NP meeting the licensure and educational requirements in South Carolina and/or the border states of Georgia and North Carolina.

Provider

During the child's routine physical or encounter, the provider will assess the child's needs and whether he or she will benefit from participating in an obesity counseling intervention program. The provider must bill the HCPCS encounter code for both the provider assessment and the dietitian assessment.

The provider must schedule a follow-up encounter with both child and parent or legal guardian to evaluate the progress the child has made, review their compliance with the exercise and nutritional plan provided by the dietitian, and render all behavioral modification suggestions and plans. Each time the provider and dietitian sees the child, he or she must clearly document the child's progress, activities, and compliance with the treatment plan. The provider must record height and weight percentile in the child's medical records.

Children ages 2 to 7 are at-risk for being overweight when they are within the 85th and 95th percentile in weight and age. Children ages 2 to 7 are considered overweight when they are in the 95th percentile for weight for their age. The provider determining the need for an obesity intervention program must communicate with the child and his or her parents or legal guardian the weight goal and plans that will lead to an incremental decrease in weight loss. The weight loss goals, laboratory work and exercise plan must be documented in the child's medical records.

It is recommended that overweight children ages 7 to 16 should strive for weight loss of one to two pounds per month; more rapid weight loss may be initiated at the provider's discretion and the child's healthcare needs.

In addition, it is recommended that overweight children who are 16 years old or post pubertal should strive for 10% weight loss from baseline over six months. The provider should schedule a reassessment after six months of treatment.

Dietitian

The dietitian is responsible for reviewing the child's habits, providing education with the child and his or her parent or legal guardian, reinforcing the importance of exercise, developing a nutritional plan, and establishing weight goals. The dietitian must document the child's progress, activities, and compliance with the nutritional and exercise plan. The dietitian must document the child's medical record as to the progress and compliance as stated above.

Additional Services

A request for services in excess of the limits above requires medical necessity verification by an SCDHHS Medical Director. The provider must submit a letter of medical necessity and all supporting documentation to:

SCDHHS

Attention: Medical Director

PO Box 8206

Columbia, SC 29202

Family Planning Program

See the E&M services section of this manual for more guidance on this covered program.

FQHC Reporting Positive Screens

Family Planning beneficiaries have Medicaid coverage for a limited set of services. This coverage does not include treatment, medication, or office visits for many of the conditions that a FQHC provider may identify during the physical examination or annual family planning visit. If a problem or condition is identified during the physical examination or annual family planning visit, the FQHC should schedule a follow-up visit with the patient in order to address the problem. Family Planning patients will be responsible for any fees associated with follow-up visits. All follow-up visits for uninsured Family Planning beneficiaries should follow the FQHC provider's established policies and procedures for treating uninsured patients.

For data collection and monitoring purposes, SCDHHS requests that FQHCs report positive screening results when a problem or condition is identified during the physical examination or annual family planning visit. The instructions that follow describe the process for reporting these positive screenings.

Instructions

When a problem or condition requiring follow-up care is identified, FQHCs should include the Positive Screening Code along with one or more of the modifiers listed below as a separate line on the Encounter Claim Form.

Modifier Instructions

FQHCs must use the appropriate modifier from the list below. Up to four modifiers can be used for the Positive Screening Code (e.g., if a patient is scheduled to receive a follow-up visit for more than one positive screening, include modifiers for all positive screenings):

- If scheduling a follow-up visit for a patient for a positive diabetes screen, use modifier P1.
- If scheduling a follow-up for a patient for a positive cardiovascular screen, use modifier P2.
- If scheduling a follow-up visit for a patient for any positive cancer screen, use modifier P3.
- If scheduling a follow-up visit for a patient for any mental or behavioral health screens, use modifier P4.

- If scheduling a follow-up visit for a patient for any other condition or problem, use modifier P5.

Rural Health Clinic (RHC)

RHC services are primarily ambulatory, OP office type services furnished by physicians and other approved providers at a clinic located in a rural area. When a rural area has been designated as a shortage area by the U.S. Census Bureau and has been certified for participation in Medicare in accordance with 42 CFR Part 405, Subpart X and 42 CFR Part 491, Subpart A, an RHC certified under Medicare will be deemed to have met the standards for certification under Medicaid.

RHCs must be under the medical direction of a physician and have a health care staff that includes one or more physicians and one or more NPs or PAs. The staff may also include ancillary personnel who are supervised by the professional staff. The staff must be sufficient in numbers to provide the services essential to the operation of the clinic or the center. A physician, NP, nurse midwife or PA must be available to furnish patient care services at all times during the RHC's hours of operation. The mid-level NP, nurse midwife or PA must be available at least 50% of the RHC's clinical hours.

The RHC and clinical staff must be in compliance with applicable federal, state and local laws for licensure, certification and/or registration.

The authority for RHC services is found in Sections 1861(aa), 1102 and 1871, of the Social Security Act, and at 42 CFR Part 405, Subpart X; 42 CFR Section 440.20(b); and 42 CFR Part 491, Subpart A.

Beneficiaries Enrolled in a Managed Care Plan

A beneficiary enrolled in a Medicaid Managed Care Program, such as a MCO or the Medical Home Network — Medically Complex Children's Waiver (MCCW) program, must receive all health care services through that plan. Each plan specifies services that are covered, those that require prior authorization, the process to request authorization and the conditions for authorization. Please refer to the Administrative and Billing Manual for information on how to verify a beneficiary's enrollment in a managed care plan.

All questions concerning services covered by or payments from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid beneficiary who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a beneficiary enrolled in a managed care plan will be referred to that plan. A list of MCOs and the MCCW provider with which Medicaid has a contract to provide health care services is available on our website at: <http://www.scdhhs.gov/>. Please note, Medicaid staff makes every effort to provide complete and accurate information on all inquiries as to a beneficiary's enrollment in a managed care plan. Because eligibility information as to which plan the patient must use is available to providers, a FFS claim will not be paid even when information is given in error by Medicaid staff.

Core Services

Core services are reimbursed through encounter codes using an all-inclusive rate (up to the current year's RHC cap or CMS-approved rate) that reflects the cost of service. RHC core services are outlined in the manual subsections below.

Encounter Services

Currently the definition of a visit is a face-to-face encounter in the RHC setting (or client's home) between a client and the physician, PA, NP, CNM, chiropractor, clinical psychologist or clinical social worker, as required by State Law, during which an RHC core service is furnished. For billing purposes, SCDHHS has deemed a "visit" as an "encounter".

Only one encounter code is allowed per day with the exception of the psychiatry and counseling encounter, which can be billed in addition to another encounter on the same day.

RHC services are covered when furnished to clients at the clinic, SNF or the client's place of residence. Services provided to hospital patients, including ER services, are not considered RHC services.

Physician Services

Physician services refer to professional services (diagnosis, treatment, therapy, surgery and consultation) that a physician performs at the clinic, a nursing facility or the client's place of residence.

Physician Assistant, Nurse Practitioner, and Certified Nurse Midwife

PA, NP and CNM services refer to the professional services performed by one of these providers who meets the following requirements:

- Is employed by or receives payment from the RHC.
- Is under a physician's general (or direct, if required by State Law) medical supervision.
- Provides services according to clinic policies or any physician's medical orders for the care and treatment of the client.
- Provides the type of services that Medicare/Medicaid would cover if provided by a physician or incidental to physician services.

Screening Brief Intervention and Referral to Treatment Initiative

Effective with dates of service on or after July 1, 2014, the following codes and billing procedures must be utilized in order to receive payment for the Screening, Brief Intervention and Referral to Treatment (SBIRT) services.

SCDHHS began coverage for SBIRT in 2011 to improve birth outcomes and the overall health of moms and babies. SCDHHS has partnered with stakeholders across the state to help identify and treat pregnant beneficiaries who may experience alcohol or other substance abuse issues, depression, tobacco use or domestic violence. SBIRT services (screening and, when applicable, a brief intervention) are reimbursable in addition to an E&M code for pregnant women and/or those who are in the 12-month postpartum period.

SCDHHS will continue to use the HCPCS codes for screening and intervention. The HD modifier will now be required when the services rendered indicate a positive result and/ or when a referral is completed.

Providers must use the appropriate HCPCS screening code and the HD modifier when an SBIRT screening result is positive. Additionally, providers must use the appropriate HCPCS brief intervention code with the HD modifier when a referral to treatment is made in conjunction with the brief intervention. These changes in billing procedures apply for Healthy Connections Medicaid members enrolled in both the Medicaid FFS and Medicaid Managed Care program.

- Screening — reimburses once per fiscal year
- Brief Intervention — reimburses twice per fiscal year

The Institute for Health and Recovery's Integrated Screening Tool, which is a validated and objective resource, must be used to receive reimbursement for screening and intervention. When billing for SBIRT services using the appropriate HCPCS codes, providers must bill using both their individual and group NPI numbers on the CMS-1500 form or an electronic claim. A copy of this screening tool is located with the Forms information on the provider portal.

Application of Fluoride Varnish

Trained staff in a primary care setting must bill the CPT code on the CMS-1500 form when applying fluoride varnish. This code replaces the ADA code when the service is provided in a primary care setting.

Healthy Connections children can receive topical fluoride varnish during sick or well child visit from the eruption of their first tooth through the month of their 21st birthday. Primary care providers are encouraged to focus their efforts on children through age five, who are at high-risk for dental caries. This follows the recommendations of the AAP and the United States Preventive Services Task Force.

RHC Adult Nutritional Counseling Program

The obesity initiative targets those obese individuals who do not meet the criteria for gastric bypass surgery or related services. Obesity is defined for this program as an adult patient with a BMI of 30 or greater.

Currently, this program will exclude the following categories of beneficiaries:

- Pregnant women.
- Patients, for whom medication use has significantly contributed to the beneficiary's obesity as determined by the treating physician, are not eligible to participate in the obesity program.
- Beneficiaries who have had or scheduled to have bariatric surgery/gastric banding.
- Beneficiaries actively being treated with gastric bypass surgery/vertical-banded gastroplasty.

There is an exhaustive list of medications that could contribute to obesity. Examples of medications that may cause weight gain are:

- Atypical antipsychotics (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone)
- Long-term use of oral corticosteroids (prednisone, prednisolone)
- Certain anticonvulsant medications (valproic acid, carbamazepine)
- Tricyclic antidepressants (amitriptyline)

Please note, for Healthy Connections Medicaid members also receiving Medicare benefits, SCDHHS will only pay secondary payments to Medicare.

The program consists of intensive behavioral therapy for obesity and includes three factors:

- Screening for obesity in adults using measurement of BMI calculated by dividing the patient's weight in kilograms by the square of height in meters.
- Dietary (nutritional) assessment.
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions related to diet and exercise.

The following billing instructions apply to FFS only. Providers who submit claims to MCOs should refer to the provider contract with the appropriate MCO for billing instructions.

RHCs must bill for obesity benefits utilizing their GP legacy/NPI number and not their RHC legacy/NPI number.

During the patient's routine physical exam or office visit, the provider will assess the patient's needs and whether they will benefit from participating in an obesity intervention program. The provider can either schedule the patient for an independent visit or may bill the initial obesity visit on the same

day as a routine physical exam or E&M service. If the provider chooses to bill for both services on the same day, the provider must append the 25 modifier to the E&M service. This will prevent claim edits due to errors related to the NCCI. This policy only applies to the initial obesity visit.

All obesity visits must be billed utilizing the appropriate HCPCS code, except for the initial visit. The initial visit must be billed by appending a South Carolina modifier to the HCPCS code. Subsequent visits may be billed as a one-on-one session between the provider and the patient or in a group setting. When billing for a group setting, the provider must append the HB modifier to HCPCS code indicating that a group session has been rendered. All groups are limited to a maximum of five patients per group. The chart of valid codes and usages are located on the provider portal.

All obesity visits must include the following components listed below:

- **Assess:** Ask about and assess behavioral health risk and factors affecting behavioral change goals/methods.
- **Advise:** Give clear, specific and personalized behavioral advice, including information about personal health, harms and benefits.
- **Agree:** Collaborate with the patient to select appropriate treatment goals and methods based on the patient's interest and willingness to change behavioral patterns and habits.
- **Assist:** Use behavioral change techniques (self-help and/or counseling) to aid the patient in achieving agreed upon goals by acquiring the skills, confidence, and social, environmental supports for behavioral change, supplemented with adjunctive medical treatments when appropriate.
- **Arrange:** Schedule follow-up contacts to provide ongoing assistance and or support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

The provider must also emphasize the importance of exercise, developing a realistic exercise plan with goals. The obesity intervention plan must be documented and maintained in the patient's medical record. The provider will arrange for an individual nutritional assessment to be provided by a Medicaid enrolled licensed dietitian.

The provider must schedule a follow-up exam with the patient to evaluate the progress the patient has made, reviewing compliance with the exercise plan and nutritional plan provided by the dietitian. Each time the provider sees the patient, he or she must clearly document the patient's progress, activities and compliance with the treatment plan. The provider must record the patient's BMI in the chart.

Services will be reimbursed for places of service 11 (office) and 22 (clinic). All service information must be written and maintained in the patient's medical record. All services are subject to review and recoupment by the Division of Program Integrity.

Dietitian

The dietitian is responsible for reviewing the patient's habits, providing education, reinforcing the importance of exercise, developing a nutritional plan and establishing goals. The dietitian must document the patient's progress, activities and compliance with the nutritional plan, and compliance on exercise. A written report must be submitted to the ordering provider each time the patient is seen individually or in a group/class setting. The records must be sent to the ordering provider within 48 hours after the patient receives the nutritional counseling visit. The dietitian must maintain complete records of the nutritional plan, compliance and exercise plan in the patient's medical record.

The dietitian must bill the initial nutritional counseling visit utilizing a one-on-one, face-to-face, 30-minute session. All subsequent obesity visits must be billed utilizing a one-on-one, 30-minute session between the dietitian and the patient or in a group setting. When billing for a group setting, the dietitian must append the HB modifier. All groups are limited to a maximum of five patients per group.

Additional Services

If the provider has completed a series of six visits and the patient has been compliant with the treatment plan and the provider has determined that the patient would benefit from additional treatment, the provider must submit documentation of medical necessity to:

SCDHHS

Attention: Medical Director

PO Box 8206

Columbia, SC 29202

In order to receive additional visits not to exceed six additional provider visits and six additional nutritional counseling sessions within a 12-month period, the following documentation must be submitted to SCDHHS by the physician, NP or PA only:

- A letter of medical necessity
- Patient notes
- BMI start and end
- A1C
- Dietitian reports

- Exercise plan and notes on adherence

All requests will be reviewed by SCDHHS Medical Directors for medical necessity and compliance with the obesity program.

Additional Resources

For additional resources, providers should visit the SCDHEC's Obesity Resources for Community Partners web page at: <https://www.scdhec.gov/health/nutrition-obesity-physical-health/resources-community-partners>.

Some examples of current programs include:

- Statewide Obesity Action Plan
- Community Transformation Grant
- Worksite Wellness
- FitnessGram
- ABC Grow Healthy
- Farm to School
- SNAP-Ed

RHC Children's Nutritional Counseling Program

RHCs must follow all the guidelines listed in both the provider and dietitian sections of the obesity policy, and are subject to all limitations and benefits. For dates of service on or before September 30, 2015, RHCs must bill utilizing the CPT, ICD-9 and HCPCS codes and modifier combinations found on the provider portal. RHCs must bill utilizing their GP legacy number and NPI combination in order to receive accurate reimbursement. All documentation standards listed in this policy apply.

For dates of service on or after October 1, 2015, RHCs must bill utilizing the CPT, ICD-10, and HCPCS codes and modifier combinations found on the provider portal. RHCs must bill utilizing their GP legacy number and NPI combination in order to receive accurate reimbursement. All documentation standards listed in this policy apply.

Medicaid-eligible children under the age of 21 may receive unlimited E&M visits as long as the services are medically necessary. For this policy the word "provider" is defined as a physician, PA or NP meeting the licensure and educational requirements in South Carolina and/or the border states

of Georgia and North Carolina. All services must be rendered within the SCMSA. SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

Provider

During the child's routine physical or office visit, the provider will assess his or her needs for an obesity counseling intervention program. The provider must schedule the child for an independent visit for an E&M service to treat him or her for obesity. The provider must bill the appropriate level E&M service and document provided services in the child's medical record.

The provider must emphasize the importance of exercise, develop a realistic exercise plan, with goals and document the visit in the child's medical record. Children must be accompanied by a parent or legal guardian, and all treatment plans must be reviewed with a parent or legal guardian present. The provider will arrange for an individual nutritional assessment to be provided by a licensed and Medicaid-enrolled dietitian, if medically necessary.

The provider must schedule follow-up exams with both child and parent or legal guardian to evaluate the progress the child has made, review compliance with the exercise and nutritional plan provided by the dietitian, and render behavioral modification suggestions and plans. Each time the provider sees the child, he or she must clearly document the child's progress, activities and compliance with the treatment plan. The provider must record height and weight percentiles in the child's medical records.

Children ages 2 to 7 are at risk for being overweight when they are between the 85th and 95th percentile in weight and age. Children ages 2 to 7 are considered overweight when they are in the 95th percentile for weight for their age. The provider determining a need for an obesity intervention program must communicate with the child and his or her parents or legal guardian the weight loss goal and plans that lead to an incremental decrease in weight loss. The weight loss goals, laboratory work, and exercise plan must be documented in the child's medical records.

It is recommended that overweight children ages 7 to 16 should strive for weight loss of one to two pounds per month; more rapid weight loss may be initiated at the provider's discretion and the child's healthcare needs.

In addition, it is recommended that overweight all children who are 16 years old or post-pubertal should strive for 10% weight loss from baseline over six months. The provider should schedule a reassessment after six months of treatment.

Dietitians

The dietitian is responsible for reviewing the child's habits, providing dietary education for the child and his or her parent or legal guardian, reinforcing of the importance of exercise, developing a nutritional plan and establishing weight goals. The dietitian must document the child's progress, activities, and compliance with the nutritional and exercise plan. The provider must submit a written

progress report to the ordering provider each time the child is seen individually or in a group/class setting. The progress report must be submitted to the ordering provider within 48 hours after the nutritional counseling visit. The dietitian must maintain complete records of the nutritional plan, compliance and exercise plan in the child's medical records.

The dietitian must bill the initial nutritional counseling visit utilizing HCPCS code 97802, which is a one-on-one, face-to-face 15-minute session. The dietitian may bill a maximum of two units for the initial visit. All subsequent obesity visits must be billed utilizing HCPCS code 97803, which is a re-assessment and intervention, individual, face-to-face visit with the patient, each 15 minutes. A subsequent nutritional counseling visit is a one-on-one session, with the patient or a session between the dietitian and patient in a group setting. The dietitian may bill 30-minute sessions, if medically necessary, which means that the dietitian would bill a maximum of two units in a day and a maximum of 10 units within a year. When billing for a group setting, the dietitian must append the HB modifier to HCPCS code. Group nutritional counseling sessions are limited to a maximum of five patients per group.

Additional Services

A request for additional services in excess of the limits above requires medical necessity verification by an SCDHHS Medical Director. Providers must submit a letter of medical necessity and all supporting documentation to:

SCDHHS
Attention: Medical Director
PO Box 8206
Columbia, SC 29202

Preventive Services

Please refer to the Utilization Management section of this manual for more information regarding preventive services.

NON-COVERED SERVICES

Evaluation and Management Services

Telemedicine

The following interactions do not constitute reimbursable telemedicine or telepsychiatry services and will not be reimbursed:

- Telephone conversations
- Email messages
- Video cell phone interactions
- Facsimile transmissions

- Services provided by allied health professionals

Unusual Travel

CPT procedure codes indicating medical testimony, special reports for insurance, educational services for groups, and data analysis are non-compensable by Medicaid.

Pediatrics and Neonatology**Routine Newborn Circumcision**

Routine newborn circumcisions are non-covered services.

EPSDT

The following services are not covered under EPSDT:

- Experimental or investigational treatments.
- Services or items not generally accepted as effective and/or not within the normal course and duration of treatment.
- Services for caregiver or provider convenience.
- HCBS Waiver
- Services for which South Carolina Healthy Connections Medicaid has a waiver program are not considered to be State Plan benefits, and therefore, are not a benefit under EPSDT. For example, items such as respite, vehicle modifications and home modifications are not covered.
- Sports, camp or college physical examination.

Obstetrics and Gynecology**Infertility Procedures**

Any medications, tests, services, or procedures performed for the diagnosis or treatment of infertility are non-covered.

Family Planning

Family Planning services required to manage or to treat medical conditions and/or diseases, whether or not such procedures are also related to preventing or delaying pregnancy, are not covered. Services to address side effects or complications (e.g., blood clots, strokes, abnormal Pap smears, etc.) associated with various family planning methods requiring medical interventions (e.g., blood clots, strokes, abnormal Pap smears, etc.) other than changing the birth control method, should not be billed using an FP modifier or Family Planning diagnosis code.

Many procedures that are performed for “medical” reasons also have family planning implications. When services other than Family Planning are provided during a family planning visit, these services must be billed separately using the appropriate CPT/HCPSC codes and modifiers if applicable. Examples of these services include:

- Sterilization by hysterectomy.
- Abortions.
- Hospital charges incurred when a beneficiary enters an OP hospital/facility for sterilization purposes, but then opts out of the procedure.
- Inpatient hospital services.
- Removal of an IUD due to a uterine or pelvic infection.
- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions.
- Diagnostic or screening mammograms.
- Treatment of medical complications (e.g., perforated bowel or bladder tear) caused by, or following a Family Planning procedure.
- Any procedure or service provided to a woman who is known to be pregnant.
- Removal of contraceptive implants due to medical complications.
- Routine gynecological exams (diagnosis code Z01.411 or Z01.419) in which contraceptive management is not provided.

Note: Beneficiaries are allowed one permanent sterilization procedure per lifetime.

Specialty Care Services

Consultations Exclusions

Situations in which consultations generally are excluded from coverage are as follows:

- Physicians within the same specialty who are partners cannot be paid consultation fees for visits to the same patient unless one partner's sub-specialty is unique to a particular situation.
- Consultations required by hospital rules and regulations, or consultations between colleagues who exchange medical opinions as a matter of courtesy and normally without charge, are not covered.

- Anesthesia consultations are not covered on the same date as surgery or the day prior to surgery, if part of the pre-operative assessment.
- Follow-up consultations are not covered when the total or specific care of a patient is transferred from the attending physician to the consultant.

Psychiatric and Counseling Services

The following services are non-compensable:

- Psychoanalysis
- Multiple-family group psychotherapy
- Narcosynthesis for psychiatric diagnostic and therapeutic purposes (e.g., sodium amobarbital [amytal] interview)
- Individual psycho-physiological therapy incorporating biofeedback training (20–30 minutes)
- Individual psycho-physiological therapy incorporating biofeedback training (45–50 minutes)
- Hypnotherapy

Psychotherapy services are non-covered in an inpatient setting when reimbursement of this service is included in the hospital reimbursement.

Ophthalmology and Optometry Services

Part I — Vision Care Services

The following services are non-covered under the Vision Care program:

- Routine eye exams for beneficiaries beginning on their 21st birthday and older.
- Refractions for beneficiaries beginning on their 21st birthday.
- Lenses and frames for beneficiaries beginning on their 21st birthday.
- Optometric hypnosis.
- Broken appointments.
- Special reports.
- Extended wear contact lenses, cosmetic lenses, tinted and/or colored contacts.
- Transitional and progressive lenses.

Part II — Diagnostic Ophthalmology Services

Glare Testing

This is considered non-standardized and has not been proven effective in the diagnosis of visual disabilities. Therefore, no separate reimbursement is allowed for this procedure.

Schirmer Test

This is considered an integral part of the ophthalmological or E&M exam; separate reimbursement for this test is not allowed.

Orthotic or Pleoptic Training: Non-covered

Color Vision Examination: Non-covered

Dark Adaptation Examination: Non-covered

Radial Keratotomy: Non-covered

Vision Screenings: Non-covered for those individuals age 21 or over

Cardiology

Vascular Studies

Thermography is non-covered.

Dermatology

Services provided for cosmetic reasons are non-covered.

Physical Medicine and Therapy

Biofeedback therapy is a non-covered service.

Hyperbaric Oxygen Therapy

No program payment may be made for HBO in the treatment of the following conditions:

- Cutaneous, decubitus and stasis ulcers
- Chronic peripheral vascular insufficiency
- Anaerobic septicemia and infection other than clostridial
- Skin burns (thermal)
- Senility
- Myocardial infarction

- Cardiogenic shock
- Sickle cell crisis
- Acute thermal and chemical pulmonary damage (i.e., smoke inhalation with pulmonary insufficiency)
- Acute or chronic cerebral vascular insufficiency
- Hepatic necrosis
- Aerobic septicemia
- Non-vascular causes of chronic brain syndrome (Pick's disease, Alzheimer's disease, Korsakoff's disease)
- Tetanus
- Systemic aerobic infection
- Organ transplantation
- Organ storage
- Pulmonary emphysema
- Exceptional blood loss anemia
- MS
- Arthritic disease
- Acute cerebral edema

Topical Application of Oxygen

This method of administering oxygen does not meet the definition of HBO therapy as stated above. Also, its clinical efficacy has not been established. Therefore, no reimbursement is allowed for the topical application of oxygen.

General Surgery Guidelines

Certain surgical procedures are routinely not covered. These non-covered procedures typically fall into one of the following categories:

- Do not restore a bodily function.

- Are performed for cosmetic reasons.
- Have an alternative non-operative treatment.
- Frequently are performed for less than adequate diagnostic indications.
- Are not proven effective.
- Are experimental/investigational in nature.
- Are for the convenience of the patient.

No reimbursement will be made for subsequent procedures that do not add significantly to the complexity of the major surgery or are rendered incidentally and performed at the same time as the major surgery (e.g., incidental appendectomies, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernias).

Surgical Guidelines for Specific Systems

Integumentary System

Lesion Removal

Medicaid will not provide coverage for excision/treatment of non-malignant dermal lesions and dermal anomalies under the following circumstances:

- The treatment is performed for cosmetic or emotional purposes.
- The therapy is experimental or investigational.

Cosmetic Procedures

Cosmetic surgery or expenses incurred in connection with such services are non-covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt repair of accidental injury (i.e., as soon as medically feasible), or for the improvement of the functioning of a malformed body member. This exclusion does not apply to surgery for therapeutic purposes which coincidentally also serves some cosmetic purposes.

Cosmetic otoplasty is not covered under normal circumstances. Payment will be considered for otoplasty procedures for children under 21, but only if there is documented evidence of psychological trauma because of their appearance. A psychiatric evaluation performed by a psychiatrist recommending treatment, plus pertinent medical documentation, must be attached to the claim. Lack of, or insufficient documentation will result in a rejected claim. All otoplastic procedures must be preauthorized by KEPRO, the QIO contractor.

Repair of the following birth defects is not considered cosmetic surgery: cleft lip, cleft palate, clubfoot, webbed fingers and toes, congenital ptosis, and other birth defects which impair bodily functions.

Male Genital System

Routine newborn circumcisions are non-covered services.

Anesthesia Services

The following CPT modifiers are non-covered:

P1 — A normal healthy patient

P2 — A patient with mild systemic disease

P3 — A patient with severe systemic disease

P4 — A patient with severe systemic disease that is a constant threat to life

P5 — A moribund patient who is not expected to survive without the operation

P6 — A declared brain-dead patient whose organs are being removed for donor purposes

These risk factor codes are non-covered.

Pain Management Services

There is no reimbursement to physicians or CRNAs for the set-up or subsequent daily management of patient-controlled analgesia pumps. Behavioral modification, PT, psychiatric services, and related services are also non-compensable as pain management or pain therapy services.

Pathology and Laboratory Services**Clinical Laboratory Improvement Amendments (CLIA)**

The following codes are non-covered:

- Ovulation tests by visual color comparison methods for human luteinizing hormone.
- Fern test.
- Post-coital direct, qualitative examinations of vaginal or cervical mucous.

Rural Health Clinic**Services and Supplies**

Supplies, injections, etc., are not billable services. These services and supply costs are included in the encounter rate when provided in the course of a physician, PA, NP, CNM, chiropractor, clinical

psychologist, and/or clinical social worker visit. The types of services and supplies included in the encounter are:

- Commonly provided in a physician's office.
- Commonly provided either without charge or included in the RHC's bill.
- Provided as incidental, although an integral part of the above provider's services.
- Provided under the physician's direct, personal supervision to the extent allowed under written center policies.
- Provided by a clinic employee.
- Not self-administered (drug, biological).

4

UTILIZATION MANAGEMENT

PRIOR AUTHORIZATION

Pre- and Post-Payment Review

All Medicaid claims, including claims for surgery, are paid through an automated claims processing system. These claims are subject to pre-payment edits and may require documentation. If a pre-payment edit is received, providers must file a new claim and submit documentation to support medical necessity.

Post-payment reviews are conducted regarding utilization, appropriateness, medical necessity and other factors.

All claims and reimbursements are subject to post-payment monitoring and recoupment if review indicates a claim was paid inappropriately or incorrectly. Providers are required to maintain and disclose their records consistent with the Provider Administrative and Billing Manual.

SCDHHS reserves the right to request medical records at any time for purposes of medical justification and/or review of billing practices.

Utilization Review Services

SCDHHS contracts for utilization review services with KEPRO, the current QIO contractor.

The QIO review consists of:

- Pre-surgical justification for all hysterectomies.
- Select preauthorization review.
- Support documentation review.
- A retrospective review of a sample of paid inpatient/OP hospital claims.
- Select project studies as determined by SCDHHS.

Screening criteria may be obtained upon request from KEPRO. Any questions or concerns should be directed to KEPRO customer service at +1 855 326 5219 or emailed to:

atrezzoissues@Kepro.com. Please be advised that a beneficiary should not contact KEPRO directly.

Telephone or written approval from the QIO is not a guarantee of Medicaid payment. All cases will be subject to retrospective review to validate the medical record documentation.

SCDHHS reserves the right to review retrospectively any case that has received prior approval to assure accuracy and compliance with South Carolina Medicaid guidelines and federal requirements.

Instructions for Obtaining Prior Approval

The responsibility for obtaining pre-admission/pre-procedure review rests with the attending physician. The physician must submit all necessary documents, including the Request for Prior Approval Review Form, to KEPRO.

Requests for prior authorizations from KEPRO may be submitted using one of the following methods:

KEPRO Customer Service: +1 855 326 5219
KEPRO Fax: +1 855 300 0082
Provider Issues Email: atrezzoissues@Kepro.com

If the beneficiary has a primary coverage through Medicare or any other private health insurance, prior authorization by KEPRO is not required.

The QIO reviewer will screen the medical information provided, using appropriate QIO or InterQual criteria for non-physician review.

If criteria are met, the procedure will be approved and an authorization number assigned. Notification of the approval and authorization number will be given by written confirmation to the physician. Write this number in block 23 of the CMS-1500 claim form.

If criteria are not met, or a case is otherwise questioned, the QIO reviewer will refer the procedure request to a physician reviewer. If the physician reviewer cannot approve the admission/procedure based on the initial information provided, he or she will make a reasonable effort to contact the attending physician for additional supporting documentation of the need for the procedure.

The physician reviewer will document any additional information provided, as well as his/her decision regarding the medical necessity and appropriateness of the procedure.

Review personnel will assign an authorization number (if the procedure is approved), and a written copy of the authorization number will be sent to the physician.

If the physician reviewer cannot approve the procedure based on the additional information, he or she will document the reasons for the decision. QIO review personnel will attempt to notify the attending physician's office of the denial.

QIO will verify all initial procedure denial decisions by issuing written notices to the attending physician.

The attending physician may request a reconsideration of the initial denial decision by submitting a written request outlining the rationale for recommending the procedure. Reconsideration may be requested whether the case was pre-procedure or post-procedure reviewed. The request should be in writing to KEPRO. If a case is denied upon reconsideration, the determination is final and binding upon all parties (CFA 473.38).

Points of Emphasis for Prior Authorization

KEPRO will accept medical review documentation via facsimile, telephone or via their website. Providers are responsible for verifying beneficiary eligibility prior to the prior authorization request being submitted and again prior to performing a service. Eligibility and managed care enrollment status may change during the time a request is submitted and approved and the actual date the procedure is performed.

A prior authorization request for beneficiaries enrolled in a MCO must be handled by the MCO. If you have any additional questions regarding the MCO you may contact the MCO's Provider Services department, or the Managed Care area at +1 803 898 4614. Contact information for the MCOs is located in the Managed Care Supplement.

Physician providers are responsible for providing the prior authorization number to any facility or medical provider who will submit a Medicaid claim.

The hysterectomy policy has changed.

Quality Improvement Organization (QIO) Authorization

SCDHHS will allow for the review and prior authorization of additional mental health visits (psychotherapy, family psychotherapy and group psychotherapy). The beneficiary's physician must request, in writing, prior authorization through SCDHHS to override the 12 allowable mental health visits. The prior authorization request must be submitted to the SCDHHS designated QIO by faxing the DHHS Mental Health Form (in the Forms section of the provider portal). The signature of the physician making the request must be on the form. The prior authorization request must include sufficient clinical information to determine the need for additional mental health visits. The physician will be notified via QIO approval letter if the authorization request is approved and prior authorizations will only be indicated for a six-month period.

All requests should be sent to the current QIO, KEPRO, using one of the following methods:

Fax: +1 855 300 0082

Web portal: <http://scdhhs.kepro.com>

Other KEPRO contact information:

Customer Service: +1 855 326 5219

Provider Issues Email: atrezzoissues@Kepro.com

When an emergency situation arises and there is insufficient time to obtain prior approval, the treating physician should prepare the required documentation and submit it for retrospective review. Claims requiring retrospective review are still subject to timely filing guidelines.

Breast Cancer Susceptibility Gene 1 and 2 (BRCA)

Effective August 1, 2019, prior authorization must be obtained from KEPRO prior to initial or subsequent BRCA testing. One or more of the NCCN Clinical Practice Guidelines in Oncology — Genetic/Familial High-Risk Assessment: Breast and Ovarian criteria must be met.

A completed Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Request Form must be submitted to KEPRO. The form must be completed in its entirety, signed and dated by the referring provider. The provider's signature submitted on the HBOC is their attestation, to the best of their knowledge, that the information provided in the document is true, accurate and complete.

The physician must indicate one of the following on the HBOC form:

- The request is for initial BRCA1 and BRCA2 testing.
- The request is for repeat BRCA1 and BRCA2 comprehensive sequencing testing for the beneficiary because initial results are negative, or are not available, and large cell rearrangement testing is necessary.

Hysterectomies

All hysterectomies must be preauthorized by KEPRO except for those being performed on patients that are dually eligible for Medicare and Medicaid. (Please refer to Utilization Review Services within this section of the manual for more information.) All prior approval requests for hysterectomies must be in writing. The South Carolina Medicaid Surgical Justification Form and the Consent for Sterilization (DHHS 687) must be completed and submitted to KEPRO. The forms are available on the provider portal; both forms must be submitted at least 30 days prior to the scheduled surgery to KEPRO via facsimile at: +1 855 300 0082.

InterQual criteria will be used to for screening prior authorization request. In addition to meeting InterQual criteria a hysterectomy must be medically necessary and meet the following requirements:

- The individual or her representative, if any, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.
- The individual or her representative, if any, must sign and date the acknowledgement of receipt of hysterectomy information (DHHS Form 1729) prior to the hysterectomy.

Requests for prior authorizations must be submitted before the service is rendered. Exceptions to this policy include emergency, urgent case or retroactive eligibility. Emergency or urgent cases must also be submitted for approval before the claim is sent for processing.

Prior authorization, support documentation, quality assurance and quality care inquiries must be submitted to KEPRO using one of the following methods:

KEPRO Customer Service: +1 855 326 5219
KEPRO Fax: +1 855 300 0082
Provider Issues Email: atrezzoissues@Kepro.com

KEPRO urgent and emergent hysterectomy cases will be reviewed retrospectively. Please refer to Special Coverage Issues in this manual for additional Medicaid policies for hysterectomies. Cases that do not meet the QIO criteria will be referred for physician review. The physician will use clinical judgment to determine whether the proposed treatment was appropriate to the individual circumstances of the referred case. Pre-approved cases will not be subject to retrospective review by the QIO. However, SCDHHS reserves the right to review any paid claim and recoup payment when medical necessity requirements are not met. The patient and physician shall make the final decision as to whether to undergo surgery. Medicaid will not sponsor the hospital-related expenses associated with the surgery if the QIO physician consultant determines that the proposed surgery is not appropriate.

The Consent for Sterilization Form is not required if the individual was already sterile before the surgery, or if the individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible. In these circumstances, a physician statement is required. The statement must indicate the cause of the sterility or the diagnosis and description of the nature of the emergency.

Specialty Care Services

All services provided and billed are contingent upon medical necessity. SCDHHS reserves the right to request documentation to substantiate medical necessity at any time.

Certain procedures are always subject to medical review on a pre-payment basis. These procedures are listed in their respective specialty areas in this manual. If a claim is denied for reasons of "Not Medically Necessary", the provider may request a reconsideration. The request should be in writing and sent to the Division of Hospital Services at the following address:

SCDHHS
Division of Hospital Services
PO Box 8206
Columbia, SC 29202-8206

If the claim is denied a second time, the provider has the right to request an appeal within 30 days of the notice of denial. The request for an appeal should be in writing and sent to the Division of Appeals and Hearings at the following address:

SCDHHS
Division of Appeals and Hearings
PO Box 8206
Columbia, SC 29202-8206

If a hearing is necessary, a date will be arranged by the Division of Appeals and Hearings for the appellant and SCDHHS to formally review the claim(s).

Medicaid contracts with KEPRO, our QIO contractor, for utilization review services and pre-payment authorization of hysterectomies. Certain other procedures are subject to prior authorization through the Division of Hospital Services. For specific details, please refer to the Provider Administrative and Billing Manual.

Psychiatric and Counseling Services

Inpatient Admissions

SCDHHS will require prior authorization for all acute (general hospital) inpatient admissions. KEPRO, the Medicaid QIO, will perform the review and will accept prior authorization review requests via:

Fax: +1 855 300 0082
Web Portal: <http://scdhhs.kepro.com>

KEPRO nurse reviewers will screen the medical information provided using InterQual criteria. It is the responsibility of the attending physician to submit the Request for Prior Approval Review Form and all current medical documents that support the medical necessity of the admission to KEPRO. If criteria are met, the admission will be approved and an authorization number assigned and faxed to the requesting provider.

For emergent or urgent admissions, providers must contact KEPRO for authorization within 24 hours of the date of the admission.

For admission to PRTF's or inpatient psychiatric hospitals for beneficiaries under age 21, please refer to the Psychiatric Hospital Services Provider Manual.

Note: Inpatient services are excluded from the mental health visit limit.

Gastroenterology

Panniculectomy

Prior authorization is needed and should be obtained by submitting documentation to KEPRO via fax, email or website; InterQual criteria apply.

Physical and Medicine Therapy

Recipients age 21 and over who receive services in one of the settings listed in the covered services section under Physical and Medicine Therapy within this manual must be pre-authorized by the QIO, KEPRO.

Medical documentation must be submitted to KEPRO to justify the medical necessity for the PT. Documentation includes, but not limited to, patient medical history, radiology, pharmacology records and letter of medical necessity which clearly indicates the medical justification for the service being requested. Any requests sent without medical documentation will be administratively denied. InterQual criteria will be used to make all determinations.

KEPRO is responsible for the initial authorization which includes the initial evaluation and the first four weeks of therapy. After four weeks of therapy, a concurrent review is performed to re-evaluate the patient's condition and response to treatment. At that time, the physician/NP may request up to an additional eight weeks of therapy. The provider is responsible for submitting any additional medical documentation needed for KEPRO to review for prior authorization of additional therapy.

Patients with Medicare or any other payer are only required to obtain a prior authorization if Medicare or the primary carrier did not make a payment or the service is considered not covered.

SCDHHS will require prior authorization for rehabilitative therapy for children. The checkpoint will apply to private rehabilitative providers as well as to those performed in the OP hospital clinic. Requests for therapy services for all children that exceed the checkpoints for combined rehabilitative therapy services (105 hours or 420 units must be submitted to KEPRO for authorization). KEPRO will use InterQual's OP Rehabilitation criteria for medical necessity determinations. Requests for therapy services may be submitted by the PCP, NP, PA, physical, occupational or speech therapist but must follow the guidelines outlined in the Private Rehabilitative Therapy and Audiological Services Provider Manual.

Surgical Guidelines for Specific Systems

Prior Authorization for Mammoplasty and Mastectomy and Reconstructive Procedures

Reduction mammoplasty and gynecomastia, mastectomy procedures must be preauthorized by KEPRO using InterQual criteria. A Request for Prior Approval Form must be used when submitting a request for these services. A sample copy of the Request for Prior Approval Form can be found in the Forms section of the provider portal. The attending physician shall obtain prior authorization and submit all necessary documentation to KEPRO.

The following policies should be followed for reduction mammoplasty and gynecomastia:

- Prior authorization is required for all ages.
- Photographs must be submitted with all requests.
- Pathology/operative reports are no longer needed.
- KEPRO will conduct all reviews.
- Physicians are responsible for verifying beneficiary eligibility prior to the prior authorization request being submitted.
- Physicians are responsible for providing the prior authorization number to any facility or medical provider who will submit a Medicaid claim.

Reduction Mammoplasty

Reduction mammoplasty for large, pendulous breasts on a female may be considered medically necessary when InterQual screening criteria are met. Prior authorization is required for all ages. A claim is reviewed for medical necessity and must be submitted with the preoperative assessment from the patient's record.

Reconstructive Breast Surgery

Reimbursement is allowed for reconstructive breast surgery following a mastectomy performed for the removal of cancer or for prompt repair of accidental injury. Prior authorization and/or support documentation must be obtained. KEPRO is responsible for prior authorization and support documentation requests; InterQual screening criteria applies.

Breast reconstruction done for cosmetic reasons is non-covered. Augmentation is non-covered under all circumstances. Payment is made for special bras through the DME program for women who have undergone any type of mastectomy.

Gynecomastia

Although unilateral or bilateral mastectomy in a male is rarely indicated, this procedure may be allowed when medically necessary. Prior authorization must be obtained by the attending physician.

South Carolina Medicaid Request for Prior Approval Form and all necessary documentation should be sent to KEPRO; InterQual screening criteria applies.

Male Gynecomastia

Repeat Male Gynecomastia may be considered when supporting documentation meets InterQual screening criteria.

Male Genital System

Circumcisions to be performed due to medical justification require prior approval, which must be granted utilizing the Request for Prior Approval Review Form found in the “Forms” section of the appendices section within the Provider Administrative and Billing Manual. Support documentation must accompany the form and be faxed “Attention Circumcision Review” to +1 803 255 8255. Cosmetic reconstruction of the penis is non-compensable without medical justification. Prior approval must be granted by Medical Services Review before services are considered for payment.

Penile implants are non-covered unless prior approval is obtained. Reimbursement will not be allowed for penile prosthesis if the only reason is sexual dysfunction. The criteria for approval are based on medical necessity. Examples would be chronic depression as a result of sexual dysfunction or a paraplegic with decubitus problems who would benefit from better condom urine drainage.

The following support documentation is required:

- Summary of psychiatric care.
- The medical condition that surgery is expected to improve.
- History and physical.

As with cosmetic reconstruction, prior approval must be granted by KEPRO, the QIO contractor. A complete list of procedures requiring prior authorization is located on the provider portal.

Sterilization requirements are the same as for females. (Please refer to Elective Sterilization under Obstetrics and Gynecology within this section of the manual.)

Organ Transplantation

KEPRO will provide direct oversight of the Medicaid transplant program. SCDHHS will only support the referral of patients for an evaluation to CMS certified transplant centers. This will include

certified facilities that are contracted with SCDHHS as well as certified facilities that are located outside of the SCMSA (less than 25 miles of the South Carolina borders).

Group I — Kidney and Corneal

Kidney Transplantation

Medicaid will reimburse for kidney transplants. Professional services, including the nephrectomy and transplantation of the new organ, performed by a physician team, are reimbursed separately. Inclusive charges are compensable for the services rendered on behalf of the Medicaid-eligible beneficiary. Medicare coverage is primary and Medicaid will only pay if Medicare benefits are either not available or have been denied.

A Medicare denial of benefits must accompany the claim, and the patient must be End Stage Renal Disease (ESRD) enrolled with Medicaid. (Please refer to “Nephrology and End Stage Renal Disease Services” under “Specialty Care Services” in this section of the manual.)

Corneal Transplantation (Keratoplasty)

Corneal transplants are compensable. The reimbursement to the hospital includes all technical services, including donor testing and preparation.

Professional services are compensable using CPT codes 65710-65755. All general surgery guidelines apply when billing for keratoplasty.

SCDHHS will cover the cost of the corneal tissue when a corneal transplant is performed in an ASC. The ASC will be reimbursed for the transplant surgical procedure and the corneal tissue must be submitted with the HCPCS procedure code V2785 (processing, preserving and transporting covered tissue). ASC providers must attach a copy of the invoice reflecting the cost of the tissue along with the claim to avoid delays in payment.

Transportation for Medicaid Beneficiaries Requiring Group I Transplants

Transportation arrangement for Group I transplants are coordinated through the Division of Preventive Care. For information on the transportation program, you may call the PSC at: +1 888 289 0709, submit an online inquiry at: <http://www.scdhhs.gov/contact-us>, or write to:

SCDHHS
Division of Preventive Care
PO Box 8206
Columbia, SC 29202

Group II — Bone Marrow (Autologous Inpatient and OP, Allogenic Related and Unrelated, Cord, and Mismatched), Pancreas, Heart, Liver, Liver with Small Bowel, Liver/Pancreas, Liver/Kidney, Kidney/Pancreas, Lung and Heart/Lung, Multivisceral, Small Bowel

All Group II organ transplants, with the exception of Bone Marrow (Autologous Inpatient and OP, Allogenic Related and Unrelated, Cord, and Mismatched), require prior authorization from KEPRO. Referral requests for organ transplants to both in-state and OOS centers must be submitted to KEPRO before services are rendered.

Requests for prior authorizations from KEPRO may be submitted using one of the following methods:

KEPRO Customer Service: +1 855 326 5219
KEPRO Fax: +1 855 300 0082
Provider Issues Email: atrezzoissues@Kepto.com

In addition to completing the Transplant Prior Authorization Request Form, the request must also include a letter from the attending physician with the following patient information:

- The description of the type of transplant needed.
- The patient's current medical status.
- The patient's course of treatment.
- The name of the center to which the patient is being referred.

Upon approval, KEPRO will issue an authorization number to the requesting physician with instructions for its use. The transplant authorization number must be included on all claims submitted for reimbursement. Transplant Prior Authorization Request Form can be found in the Forms section of the Provider Administrative and Billing Manual.

KEPRO reserves the right to make recommendations to the provider for services at a certified center that has provided transplant services to Medicaid beneficiaries in the past. Please note that the approval of a transplant evaluation does not guarantee the approval of the actual transplant.

The appropriate transplant team, utilizing uniform professional and administrative guidelines, will determine medical necessity and clinical acceptability. For more information, please contact KEPRO at: +1 855 326 5219.

Pain Management Services**Spinal Cord Neurostimulators**

Neurostimulator now require prior authorization by KEPRO, the QIO. Please refer to the provider portal for a complete list of procedures that require prior authorization. The implantation of spinal

cord neurostimulators will be covered for the treatment of severe and chronic pain. Implantation of this device, related services and supplies, may be covered if InterQual criteria are met.

The implantation of the neurostimulator may be performed on an inpatient or OP basis according to medical necessity.

Procedure codes 63650, 63655, or 63685 may be used to bill for the implantation.

Post-Payment Review

Post-payment review of pain management services will be conducted regularly, at which time documentation of treatment and methods of resolving the source of the pain will be requested from the provider.

Radiology and Nuclear Medicine

SCDHHS will include in post-payment reviews an assessment of providers' compliance with the following policies and payment rules. Post-payment reviews indicating unnecessary radiological procedures and interpretations or non-covered or unallowable services will result in recoupment of any Medicaid payments.

- When both the ER physician and radiologist or cardiologist interpret an x-ray or EKG done in the ER, payment will be made for the interpretation and report that directly contributes to the diagnosis and treatment of the patient. The specialty of the physician rendering the service will not be the primary factor considered. The interpretation billed by the cardiologist or radiologist is payable if the interpretation is performed at the time of the diagnosis and treatment of the patient. Separate payment to the hospital medical staff is not made for interpretations performed solely for quality control and liability purposes under hospital policy.
- Reinterpretations, unordered images and second opinions are not reimbursable. Medical necessity must be documented for additional or repeat procedures for the same DOS (i.e., additional images were needed, patient in congestive heart failure, catheter placement, etc.).
- CPT procedures are compensable if ordered by an attending/ordering physician and deemed medically necessary for the diagnosis and treatment of the patient's condition.
- Routine chest x-rays without a diagnostic reason are not reimbursable.
- Radiological procedures performed as a screening mechanism, without a diagnostic reason for justification, are non-covered.
- Separate consultative procedures are non-covered. SCDHHS will also use post-payment review to determine adherence to correct coding to include:
 - Correct use of modifiers.

- Correct use of supervision and consultation codes when used in conjunction with a radiological procedure.
- Use of unlisted procedure code.
- All other service and coverage requirements listed in this section.

The incorrect use of modifiers or coding which results in an over-payment or improper payment to the provider will result in recovery of the over-payment and will result in a recovery action and/or sanction.

OTHER SERVICE LIMITATIONS

Medical Necessity

Ambulatory Care Visits

SCDHHS has modified its policy concerning the potential approval of additional ACVs. To be reimbursed for additional visits over the 12-visit limit, providers must submit a letter directly to Physicians Services requesting additional visits. The letter must be on office letterhead and include the provider's NPI number, the patient's name and Medicaid ID number, and the physician's signature. Providers must also provide the medical reasons for the request. SCDHHS Operations and Provider Relations will reply, in writing, with approval or denial and the number of additional visits granted if approved. Prescription or 'fill-in-the-blank' form documents will not be accepted. This process is closely monitored for medical necessity and abuse. Please send all requests to:

Healthy Connections Medicaid
Attention: Ambulatory Care Visit Review
PO Box 8206
Columbia, SC 29202-8206

The department's copayment policy will continue with each of the authorized additional visits.

In order to avoid possibly receiving a 977 edit for exceeding the 12 allowable ambulatory visits when filing the claim, providers must attach the letter of approval from the SCDHHS Medical Director to the claim. This letter must accompany each claim in order for it to suspend to the program area for review. Additionally, the letter of approval should be maintained in the patient's medical records in the event of a post payment review. Claims must be submitted within the timely filing guidelines.

Chiropractic Services

Medicaid will only pay for services that are medically necessary. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment. Additionally, the manipulative services rendered must have a direct therapeutic relationship to the patient's condition. Spinal axis aches, strains, sprains, nerve pains and functional mechanical disabilities of the spine are considered to provide therapeutic grounds for chiropractic manipulative

treatment (CMT). Most other non-spinal diseases and pathological disorders (e.g., rheumatoid arthritis, muscular dystrophy, MS, pneumonia and emphysema) are not considered therapeutic grounds for CMT.

Dermatology

Visits and treatments for dermatological services must be medically necessary. The patient's record must clearly document the condition and medical necessity.

EPSDT Services

Providers should obtain a prior authorization for all medically necessary non-State Plan EPSDT services prior to service provision. Providers must submit documentation of medical necessity and any additional information that will assist in the determination of service coverage.

Gastroenterology

Bariatric Surgery

Bariatric surgery is a covered service for members who meet InterQual guidelines for medical necessity. Prior authorization is required for these procedures and should be requested from KEPRO.

Radiology and Nuclear Medicine

All radiology and diagnostic services must be medically necessary and directed to the diagnosis, maintenance, improvement, and treatment of illness and/or disability. All providers must use ACR best practice guidelines when determining the need for radiology services. The purpose of the guidelines are to improve the quality of services to patients and to promote the safe and effective use of diagnostic and therapeutic radiology. Therefore, the justification for any radiological treatment or service will align with best practice guidelines and must be documented in the patient medical record.

Medicaid requires that the attending/ordering physician must order all radiology services. The NPI of the attending ordering physician must be present on the claim in order for Medicaid to reimburse for services. The attending/ordering physician will be responsible for maintaining and/or providing access to the required documentation, regardless of whether the radiology procedures were provided in a hospital, OP facility, office, freestanding imaging center or mobile unit. As noted in the Documentation Standards below, this information may be recorded in the patient medical chart, nursing reports, radiology records, inpatient or OP medical information storage areas, or in the electronic health record. Services rendered in a hospital setting must be adequately documented, including the above-cited records by the physician, with corresponding records retained by the hospital.

High-Tech Radiology

SCDHHS will review Medicaid reimbursements for high-cost diagnostic radiology procedures to determine medical necessity. Claims received with duplicated diagnosis and services ordered by

multiple providers are not reimbursable and are not considered medically necessary. Physicians, when referring patients to specialists for consultations, must send their patients with copies of films and/or a portable device (thumb drive, CD).

Standards for Documenting Medical Necessity and Provision of Services

Failure to maintain documentation that follows the above referenced (ACR/Society of Interventional Radiology [SIR]) guidelines, as well as failure to comply with other payment rules established by the policies in this section, may result in a recovery action by SCDHHS and may result in provider sanctions.

The following standards are taken from the ACR and SIR practice guideline (<http://www.sirweb.org>) for the Reporting and Archiving of Interventional Radiology Procedures revised in 2009. The guidelines must be followed when documenting medical necessity in the patient records. A medical record consists of a patient's medical information recorded in either written or electronic format. This information may be recorded in the patient medical chart, nursing reports, radiology records, inpatient or OP medical information storage areas. The medical record must include, as appropriate, the following information:

- Documentation of pre-procedural inpatient and/or office consultation.
- Immediate pre-procedure note.
- Immediate post-procedure note.
- Final report.
- Documentation of post-procedure inpatient and/or office contact.

Pre-Procedure Documentation

The pre-procedural documentation provides a baseline record of patient status and documents the indication/justification for the procedure; it should be written in the chart before the procedure. Pre-procedural documentation should, as appropriate, depending on the complexity and/or clinical urgency of the procedure, include the following information:

- The plan for each procedure to be performed.
- Indication/justification for procedure and brief history.
- Findings of targeted physical examination.
- Relevant laboratory and other diagnostic findings.

- Risk stratification, such as the American Society of Anesthesiologists Physical Status Classification.
- Documentation of informed consent (consistent with state and federal laws) or, in the case of an emergency, that this was an emergency medical procedure.

Immediate Post-Procedure Note

Before a patient is transferred to the next level of care, an immediate post-procedure note or a final report should be completed and available. The immediate post-procedure note should include, as appropriate:

- Diagnosis
- Procedure
- Physician
- Assistant
- Sedation
- Medications
- Findings
- Blood loss
- Specimen

It is not necessary for the listed items to be recorded in the order given above.

Final Report

A final report is required:

- To transmit procedural information to all members of the health care community who may participate in subsequent care of the patient.
- For legal purposes.
- For reimbursement.

Specific information to be included in this report depends on the procedure. The following elements are recommended, although all of them may not be applicable:

- Procedure
- Date
- Operator(s)
- Indication
- Method of anesthesia or sedation
- Procedure/technique: a technical description of the procedure. This information should include, as appropriate, access site (and attempted access sites), guidance modalities, catheters/guidewires/needles used, vessels or organs accessed technique, and hemostasis. Each major vessel catheterized for imaging or intervention should be noted specifically.
- For inserted medical devices, appropriate identifying information such as the product name, vendor and lot numbers.
- Medications, dosages, and route of administration, including any pre-medications and contrast agents.
- Estimated radiation dose (fluoroscopy time if no other measurement is available)
- Findings and results
- Complications
- Conclusion
- Post-procedure disposition

Out-of-State (OOS) Services

South Carolina Medicaid Service Area

All services must be rendered within the SCMSA. The SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

Treatment Rendered Outside the South Carolina Medical Service Area

The term SCMSA refers to South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina State border. Charlotte, Augusta and Savannah are considered within the service area. Medicare/Medicaid beneficiaries do not require prior approval from Medicaid for covered services from providers located within the SCMSA.

The South Carolina Medicaid Program will compensate medical providers outside the SCMSA in the following situations:

- Emergency medical services for beneficiaries traveling outside the SCMSA whose health would be endangered if necessary care were postponed until their return to South Carolina. This includes all pregnancy-related services and delivery.
- When a SCMSA physician certifies that needed services are not available within the SCMSA and properly refers the beneficiary to an OOS provider.

Prior Approval

In all but emergency situations, the referring physician should request approval prior to the OOS service. Referrals should be made to an OOS provider only when the procedure or service is not available within the SCMSA. All available resources must have been considered and indicated in the request to SCDHHS for the OOS referral. The referring physician is the one most aware of the client's medical history and needs, and will best be able to justify the necessity for the OOS referral.

Prior to contacting SCDHHS, the referring physician must first contact any OOS provider who will render a service to the client and inform them of the client's medical status. The OOS provider must confirm, in writing, that he or she will enroll in the South Carolina Medicaid program and will accept Medicaid reimbursement as payment in full. The written confirmation must be submitted to SCDHHS along with the completed Referral Request Form for OOS services.

The referring physician must complete the Referral Request for OOS Services Form. A sample copy of the form can be found in the Forms section of the Provider Administrative and Billing Manual. The written requests for OOS referral must include the following information:

- Beneficiary's name and Medicaid number.
- DOS (state as "tentative" if unscheduled at the time of request).
- An explanation as to why you feel these services must be rendered OOS versus within the SCMSA.
- Name, address, telephone and fax number of the OOS providers(s) who will render the medical services. (For example: hospital and physicians(s) involved in that patient's medical treatment.)
- A copy of the beneficiary's medical records for the past year relating to the treatment of the condition.
- Any experimental and/or investigational services identified by the referring physicians that are sponsored under a research program, or performed in only a few medical centers across the United States.

SCDHHS reserves the right to determine, on the basis of medical advisement, that the needed medical services, or necessary supplementary resources, are more readily available in the other state. SCDHHS will reject referrals for the following reasons:

- All information required on the referral form is not provided with the requested attached documentation.
- The provider rendering the service(s) is not willing to enroll in South Carolina Medicaid and adhere to the enrollment criteria.
- The provider rendering the service(s) will not accept the South Carolina Medicaid reimbursement as payment in full.

To obtain approval for OOS referrals, the OOS coordinator can be reached by fax at +1 803 255 8255, or by mail at:

Medicaid Claims Receipt
PO Box 1412
Columbia, SC 29202-1412

The referring physician is responsible for communicating with the OOS provider coordinating services for the patient. Patients being referred OOS, as well as their escorts, can be provided transportation when necessary. Transportation and any other assistance are only provided when there are no other means available to the patient to meet the needs connected with OOS travel. Adequate advance notice, as well as prior approval, is mandatory in order to make the necessary travel arrangements. Providers should contact the PSC at: +1 888 289 0709 or submit an online inquiry at: <http://www.scdhhs.gov/contact-us> for additional information.

When a beneficiary is in one of the Medicaid MCOs, the requests for OOS services must be completed through the MCO. For assistance with authorizations for MCO-enrolled members, providers should contact the MCO's Provider Services department, or the Managed Care area at: +1 803 898 4614. Contact information for the MCOs is located in the Managed Care Supplement.

Exceptions to Prior Approval

Medicaid will accept and review for medical necessity OOS claims from medical providers who did not seek any type of approval before filing their claim. However, experience has proven that these providers put themselves at an otherwise avoidable risk of non-payment or delayed payment due to the lack of knowledge of the South Carolina Medicaid claim filing policies and procedures.

Foster Children Residing Out of the SCMSA

The DSS will be responsible for all Medicaid-eligible foster children when they reside OOS. The county case manager assigned to the case should assist with medical services. Prior approval is not

required for services rendered to foster children who live OOS; however, medical necessity remains a requirement. The OOS coordinator must be contacted for two reasons:

1. The coordinator must determine whether the medical services can be reimbursed through the Medicaid program or whether DSS will reimburse the medical provider.
2. If Medicaid can reimburse for the services, proper enrollment and billing information needs to be sent to the medical providers involved.

Providers must contact the PSC at: +1 888 289 0709 or submit an online inquiry at: <http://www.scdhhs.gov/contact-us> for additional information.

Retroactive Eligibility

When retroactive eligibility for Medicaid is granted, the beneficiary is responsible for notifying the medical provider that retroactive eligibility has been granted.

For additional information regarding retroactive eligibility, please refer to the Provider Administrative and Billing Manual.

Dually Eligible Beneficiaries

When a beneficiary has both Medicare and Medicaid coverage, Medicare is considered the primary payer. However, if the beneficiary does not have Part A benefits, medically necessary inpatient hospital services will require approval.

In order to verify eligibility on Medicare/Medicaid patients, contact the PSC at: +1 888 289 0709 or submit an online inquiry at: <http://www.scdhhs.gov/contact-us>.

Ancillary and Other OOS Services

Other health care services are compensable under the South Carolina Medicaid OOS program. For OOS referral questions, please contact the PSC, submit an online inquiry, or write to SCDHHS for more information. For professional claims, providers should write to:

Medicaid Claims Receipt
PO Box 1412
Columbia, SC 29202-1412

For institutional claims, providers should write to:

Medicaid Claims Receipt
PO Box 1458
Columbia, SC 29202-1458

Office/Outpatient Exams

Laboratory Services

If the provider only extracts the specimen to send to an outside independent laboratory or hospital laboratory, then the physician cannot charge for the lab test. When the specimen is sent to the independent lab or hospital lab, report the patient's Medicaid number and the lab will bill for their service. The physician should send the specimen(s) to Medicaid-enrolled labs or the beneficiary will be responsible for the lab charges and should be informed prior to having the specimen taken.

A handling service is compensable to the physician if the specimen is collected by venipuncture or catheterization. In addition, collection of Pap smears may be charged. Please refer to Initial OB Exam within this section of the manual for handling service codes for Pap smears. Medicaid will not reimburse for special handling of specimens using either procedure code 99000 or 99001.

X-Ray and EKG Services

Medicaid will reimburse only one provider for the interpretation of diagnostic x-rays and EKGs. Reinterpretations, after a physician has interpreted and reported the test, are not allowed. Please refer to Radiology within this section of the manual for guidelines and further details.

If an outside source performed the technical part of an x-ray or EKG, then the physician should bill only the professional component.

Convenient Care Clinics

Preventative Services

The Medicaid program sponsors adult physical exams under the following guidelines:

- The exams are allowed once every two years per patient.
- The patient must be 21 years of age or older.
- For dates of service on or before September 30, 2015, procedure codes 99385-99387 and 99395-99397 for the appropriate age and diagnosis code V70.9 should be used when billing.
- For dates of service on or after October 1, 2015, procedure codes 99385-99387 and 99395-99397 for the appropriate age and diagnosis code Z00.8 should be used when billing.
 - 99385 — Preventative visit, new, age 18–39
 - 99386 — Preventative visit, new, age 40–64
 - 99387 — Preventative visit, new, age 65+

This exam may also be offered to patients with Medicare and Medicaid (dually eligible or qualified Medicare beneficiary).

- A past history for a new patient or an interval history on an established patient.
- A generalized physical overview of the following organ systems:
 - HEENT
 - Lungs
 - Abdomen
 - Skin
 - Breasts (female)
 - External genitalia
 - Heart
 - Back
 - Pelvic (female)
 - Prostate (male)
 - Rectal
 - Brief neurological
 - Brief muscular
 - Brief skeletal
 - Peripheral vascular

Family Planning Counseling must be offered if the patient is female within childbearing years or for men. (An additional Family Planning code may be billed for this service when provided. Please refer to Obstetrics and Gynecology within this section of the manual for the description of codes.)

The following lab procedures are included in the reimbursement for a physical:

- Hemocult
- Urinalysis
- Blood Sugar

- Hemoglobin

Any other lab procedures, x-rays, etc., may be billed separately. Portions of the physical may be omitted if not medically applicable to the patient's condition or if the patient is not cooperative and resists specific system examinations (despite encouragement by the physician, NP or office staff). A note should be written in the record explaining why that part of the exam was omitted.

Note: College physicals, DOT physicals and administrative physicals are not covered services.

Family Planning Services

Not all Family Planning Services can be performed in all CCCs therefore, please review your licensure and requirements from the SCLLR authority and SCDHEC.

Synagis® (Palivizumab) 90378

Prior approval is not required for up to six doses as long as they are given at least 30 days apart and meet the guidelines of the AAP for Synagis® administration. Any dose over the limit of six or administered after the RSV season (October–March) will require prior approval. If prior approval is needed, please submit requests to:

South Carolina Department of Health and Human Services
Division of Hospital Services
Attention: Medical Review/Synagis® Program
PO Box 8206
Columbia, SC 29202-8206

SCDHHS will continue to utilize the AAP 2012 guidelines for the administration of Synagis®. The AAP guidelines are available at: <http://www.aap.org>. Prior approval by the SCDHHS Medical Director will still be required for any request to administer Synagis® outside of the AAP guidelines.

However, providers should use discretion in the administration of Synagis® to those infants born between 32 and 35 weeks of gestation who do not have chronic lung disease (CLD). SCDHHS will not reimburse providers for Synagis® administration to children in this age group that do not have two or more risk factors listed in the AAP guidelines.

SCDHHS will conduct ongoing post-payment reviews of medical records relating to the administration of Synagis® and recover funds for doses given outside the AAP guidelines.

Medicaid's policy is to provide medically necessary treatment to Medicaid beneficiaries while maintaining consistent reimbursement to providers. Therefore, the drug should be drawn up with caution and used only in accordance with the AAP's guidelines, which are outlined below:

- Palivizumab, or Respiratory Syncytial Virus Immune Globulin Intravenous (Human) (RSV-IGIV), prophylaxis should be considered for infants and children younger than 2 years of age with CLD

who have required medical therapy for their CLD within six months before the anticipated RSV season.

- Patients with more severe CLD may benefit from prophylaxis for two RSV seasons, especially those who require medical therapy. Decisions regarding individual patients may need additional consultation from neonatologists, intensivists or pulmonologists.
- There are limited data on the efficacy of palivizumab during the second year of age; risk of severe RSV disease exists for children with CLD who require medical therapy. Although those with less severe underlying disease may receive some benefit for the second season, immuno-prophylaxis may not be necessary.
- Infants born at 32 weeks of gestation or earlier without CLD, or who do not meet the criteria in recommendation 1, also may benefit from RSV prophylaxis. In these infants, major risk factors to consider are gestational age and chronological age at the start of the RSV season:
 - Infants born at 28 weeks of gestation or earlier may benefit from prophylaxis up to 12 months of age.
 - Infants born at 29 to 32 weeks of gestation may benefit most from prophylaxis up to 6 months of age.
- Decisions regarding duration of prophylaxis should be individualized according to the duration of the RSV season. Practitioners may wish to use RSV re-hospitalization data from their own region to assist in the decision-making process.
- Given the large number of patients born between 32 to 35 weeks and the cost of the drug, the use of palivizumab in this population should be reserved for those infants with additional risk factors until more data are available.
- Palivizumab and RSV-IGIV are not licensed by the FDA for patients with Congenital Heart Disease (CHD). Available data indicate that RSV-IGIV is contraindicated in patients with cyanotic CHD. However, patients with CLD, who are premature, or both, who meet the criteria in recommendations 1 and 2, and who have asymptomatic acyanotic CHD (e.g., patent ductus arteriosus or ventricular septal defect) may benefit from prophylaxis.
- Palivizumab or RSV-IGIV prophylaxis has not been evaluated in randomized trials in immunocompromised children. Although specific recommendations for immunocompromised patients cannot be made, children with severe immunodeficiencies (e.g., severe combined immunodeficiency or severe acquired immunodeficiency syndrome) may benefit from prophylaxis.

- If these infants and children are receiving standard IGIV monthly, physicians may consider substituting RSV-IGIV during the RSV season.
- RSV prophylaxis should be initiated at the onset of the RSV season and terminated at the end of the RSV season. In most areas of the United States, the usual time for the beginning of RSV outbreaks is October to December, and termination is March to May, but regional differences occur. The onset of RSV infections occurs earlier in southern states than in northern states. Practitioners should contact their health departments and/or diagnostic virology laboratories in their geographic areas to determine the optimal time to begin administration.
- RSV is known to be transmitted in the hospital setting and to cause serious disease in high-risk infants. In high-risk hospitalized infants, the major means to prevent RSV disease is strict observance of infection control practices, including the use of rapid means to identify and cohort RSV-infected infants. If an RSV outbreak is documented in a high-risk unit (e.g., pediatric intensive care unit), primary emphasis should be placed on proper infection control practices. The need for and efficacy of prophylaxis in these situations has not been evaluated.
- The guidelines for modification of immunizations after RSV-IGIV have not changed. Palivizumab does not interfere with the response to vaccines.

Ultrasounds

Additional ultrasounds may be approved if supporting documentation is attached to the claim clearly indicating that the service provided is medically necessary. Examples of appropriate documentation include ultrasound reports and patient clinical records and history. If the documentation is insufficient or illegible, reimbursement for additional ultrasounds will be rejected. Claims for obstetrical ultrasounds that exceed the defined limits will be reviewed by KEPRO for medical necessity.

For MFM specialist, there is no limit on the number of ultrasounds that can be submitted for reimbursement. However, all ultrasounds provided by MFM specialists must have documentation to support medical necessity in the patient's medical record.

All ultrasound services that appear to fall outside of best practice guidelines are subject to post-payment review by the Division of Program Integrity. Multiple gestations billed with CPT add-on codes will be counted as one ultrasound if billed on the same claim with primary CPT codes.

Ultrasounds requested by the patient to determine the sex of the fetus or for other reasons are the responsibility of the patient.

When ultrasounds are performed at the hospital, a 26 modifier is required if the physician provides the interpretation. When the ultrasounds are performed in the office, no modifier is required if the

physician owns the equipment. The physician's interpretation of the ultrasound must be documented in the patient's record.

No prior authorization is necessary for ultrasounds when performed within the guidelines as stated in the CPT book. Repeat ultrasounds are allowed when medically necessary. The medical record must substantiate the reason for the follow-up ultrasounds.

Hyperbaric Oxygen Therapy

Reasonable Utilization Parameters

Payment should be made where HBO therapy is clinically practical. HBO therapy should not be a replacement for other standard, successful therapeutic measures. Depending on the response of the individual patient and the severity of the original problem, treatment may range from less than one week to several months' duration, with the average being two to four weeks. The medical necessity for use of HBO for more than two months, regardless of the condition of the patient, should be reviewed and documented before further reimbursement is requested.

Preventive Services

Preventive measures are defined as any routine service exam for adults or children when the procedures are performed in the absence of an illness or complaint(s). Generally, the South Carolina Medicaid program requires that a complaint or illness be recorded before a service is compensable. The exceptions to this policy are the EPSDT program and the Healthy Adult Physical Exams program.

The EPSDT program provides preventive health services to Medicaid-eligible children from birth to age 21 through periodic medical screenings. This includes the application of topical fluoride varnish in a primary care setting. An EPSDT screening is considered an encounter. A screening and an encounter code may not be billed on the same DOS. All EPSDT screenings must be billed using the appropriate CPT codes (99381–99385 and 99391–99395). EPSDT screening should be billed at the FQHC contract rate. For additional program policy information, please refer to the EPSDT heading within this section of the manual.

The Medicaid program sponsors adult physical exams under the following guidelines:

- The exams are allowed once every two years per patient.
- The patient must be 21 years of age or older.
- For dates of service on or before September 30, 2015, encounter code T1015 should be billed for this service, and diagnosis code V70.9 should be used.

For dates of service on or after October 1, 2015, encounter code T1015 should be billed for this service, and diagnosis code Z00.8 should be used.

This encounter code may also be offered to dually eligible Medicare and Medicaid clients until Medicare covers physicals. If a patient has both Medicare and Medicaid coverage, bill Medicaid directly.

For additional program policy guidelines, please refer to Adult Physical Exams under Preventive Care Services in this section.

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REPORTING/DOCUMENTATION

CO-SIGNATURES

Effective with dates of service on or after January 1, 2010, SCDHHS will discontinue the requirement of the physician's co-signature in a medical record when services are performed by the following professionals:

- NP
- Certified Nurse-Midwife (CNM)
- Certified Nurse Specialist (CNS)
- PA

Delegated acts and protocols that outline the scope of practice guidelines for NP, CNM, CNS or PA should be current and available in the personnel file of the supervised practitioner. Upon submission of a claim, the rendering physician is attesting that the services were accurately and fully documented in the medical record and that he or she assumes responsibility for the NP, CNM, CNS or PA. The claim also confirms the provider has certified the medical necessity and reasonableness for the service(s) submitted to Medicaid for payment.

This policy update does not supersede State Law as it relates to requirements for off-site practice protocols that outlines when co-signatures are required for PAs. These requirements can be found in Article 7 of the South Carolina Physician Assistants Practice Act section 40-47-955.

EVALUATION AND MANAGEMENT SERVICES RECORDS AND DOCUMENTATION REQUIREMENTS

The appropriate medical documentation must appear in the patient's medical record to justify medical necessity for the level of service reimbursed, including the illness, history, physical findings, diagnosis and prescribed treatment. The record must reflect the level of service billed and must be legible.

Nursing Home/Rest Home Facility Services

Progress notes are required in the patient's record for all visits, including those performed to meet the requirements of continued long-term care. The medical record must justify and reflect the level of service billed. Nursing home visits are subject to post-payment review under the same Medicaid guidelines as any other medical services.

DOCUMENTATION OF THE TEACHING PHYSICIAN

Documentation for services must include a description of the presence and participation of the teaching physician. The resident may document the encounter, to include a note that describes the involvement of the teaching physician. The teaching physician's signature is then adequate to confirm agreement.

Documentation of an encounter by the teaching physician may reference portions of a medical student's notes. The combined entries of the medical student, resident, and teaching physician must be adequate to substantiate the level of service required and billed. Documentation must include the teaching physician's signature for each encounter.

CONVENIENT CARE CLINICS

CCCs are required to send information regarding a service to the PCP by facsimile within 24 hours of the visit and maintain confirmation of receipt of the facsimile in the patient's file.

TELEMEDICINE

Documentation in the medical records must be maintained at the referring and consulting locations to substantiate the service provided. A request for a telemedicine service from a referring provider and the medical necessity for the telemedicine service must be documented in the beneficiary's medical record. Documentation must indicate the services were rendered via telemedicine. All other Medicaid documentation guidelines apply to the services rendered via telemedicine. Examples include but are not limited to:

- The diagnosis and treatment plan resulting from the telemedicine service and progress note by the health care provider.
- The location of the referring site and consulting site.
- Documentation supporting the medical necessity of the telemedicine service.
- Start and stop times.

OBSTETRICS AND GYNECOLOGY

Licensed Midwife

The following documentation must be maintained for all services provided by a Licensed Midwife:

- The midwife's initial claim for prenatal services for each beneficiary must be accompanied by signed documentation from a physician credentialed in obstetrics who agrees to provide medical back-up in the event of a complication or emergency.
- Documentation of the physician's hospital privileges must be provided to SCDHHS.

- Any changes in the physician back-up must be reported in writing to the Division of Physician Services.
- The physician who agrees to provide back-up must be enrolled as a Medicaid provider.

The following additional documentation regarding the Licensed Midwife must be kept in the patient's medical record:

- A signed consent form that documents the beneficiary's awareness that her choice of provider can be made, or changed at any point in the pregnancy.
- A certification statement provided to the physician by the midwife that the particular home is an acceptable environment for a birth.
- A copy of the plan for accessing emergency care with a confirmed source of transportation to the hospital provided to the beneficiary.
- Documentation that the beneficiary has been advised of Family Support Services available through the SCDHEC.

Sterilization Consent Form

If the consent form is correctly completed and meets the federal regulations, the claim can be approved for payment. If the consent form does not meet the federal regulations, the claim will be rejected and a letter sent to the physician explaining the rejection. If the consent form is not submitted with the claim, the claim will be rejected. If the line is rejected, a new claim must be submitted with the consent form. A sample copy of the consent form and instructions can be found in the Forms section of the Administrative and Billing Manual.

Listed below is an explanation of each field that must be completed on the consent form and whether it is a correctable error.

Consent to Sterilization

- Name of the physician or group scheduled to do the sterilization procedure. (If the physician or group is unknown, put the phrase "OB on Call"): Correctable Error.
- Name of the sterilization procedure (e.g., bilateral tubal ligation): Correctable Error.
- Birth date of the beneficiary (The beneficiary must be 21 years old when he or she gives consent by signing the consent form 30 days prior to the procedure being performed.): Correctable Error.
- Beneficiary's name (Name must match name on CMS-1500 form.): Correctable Error.

- Name of the physician or group scheduled to perform the sterilization or the phrase “OB on call”: Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Beneficiary’s signature. (If the beneficiary signs with an “X,” an explanation must accompany the consent form.): Non-correctable error.
- Date of signature: Non-correctable error without detailed medical record documentation.
- Beneficiary’s Medicaid ID number (10 digits): Correctable Error.

Interpreter’s Statement

If the beneficiary had an interpreter translate the consent form information into a foreign language (e.g., Spanish, French, etc.), the interpreter must complete this section. If an interpreter was not necessary, put “N/A” in these fields: Correctable Error.

Statement of Person Obtaining Consent

- Beneficiary’s name: Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Signature and date of the person who counseled the beneficiary on the sterilization procedure: This date must be the same date of the beneficiary’s signature date.
 - Signature is not a correctable error.
 - Date is not a correctable error without detailed medical record documentation.
 - If the beneficiary signs with an “X”, an explanation must accompany the consent form: Not a correctable error without detailed medical record documentation.
- A complete facility address: An address stamp is acceptable if legible.

Physicians Statement

- Beneficiary’s name: Correctable Error.
- Date of the sterilization procedure (This date must match the DOS that you are billing for on the CMS-1500.): Correctable Error.
- Name of the sterilization procedure: Correctable Error.

- Estimated Date of Confinement is required if sterilization is performed within the 30-day waiting period and the beneficiary was pregnant. At least 72 hours are required to pass before the sterilization procedure may be done: Correctable Error.
- An explanation must be attached if emergency abdominal surgery was performed within the 30-day waiting period. At least 72 hours are required to pass before the sterilization, and the sterilization procedure may not be the reason for the emergency surgery.
- Physician signature and date: a physician's stamp is acceptable. The rendering or attending physician must sign the consent form and bill for the service. The physician's date must be dated the same as the sterilization date or after.

The date is not a correctable error if the date is prior to the sterilization without detailed medical record documentation. In the license number field, put the rendering physician's Medicaid Provider ID or NPI number (the same number that is in block 33 on the CMS-1500 claim form). Either the group or individual Medicaid Provider ID or NPI is acceptable.

PSYCHIATRIC AND COUNSELING SERVICES

Clinical Records

Providers must maintain a clinical record for each Medicaid eligible beneficiary receiving services that fully describes the extent of the treatment services provided. The clinical record must contain sufficient medical documentation to justify medical necessity for the level of service reimbursed and clearly specify the course of treatment. The absence of appropriate and complete records may result in recoupment of previous payments by SCDHHS. Each beneficiary's clinical record must contain the following documentation:

- Full demographic information, including beneficiary's full name, contact information, date of birth, race, gender and admission date.
- Consent forms, pertinent medical history, assessments and instructions to the beneficiary.
- All physician's orders, reports of treatments and medications, and other pertinent information necessary to monitor the beneficiary's progress.
- Reports of physical examinations, diagnostic and laboratory results and consultative findings.
- Documentation of communication regarding coordination of care activities.
- The beneficiary's name on each page generated by the provider.
- The beneficiary's Medicaid number on all clinical documentation and billing records.

Clinical Service Notes

All psychiatric and psychotherapy services must be documented in a clinical service note (CSN) upon the delivery of services. The purpose of the CSN is to record the nature of the beneficiary's treatment, any changes in treatment, discharge, crisis interventions and any changes in medical, behavioral or psychiatric status. The CSN must include:

- DOS
- Name of the service provided
- Place of service
- Purpose of the contact (for psychotherapy notes, this must be tied back to the IPOC treatment goals)
- Description of treatment or interventions performed
- Effectiveness of the intervention(s) and the beneficiary's response or progress
- Duration of the service (start and end time for each service delivered)
- Signature, title, and signature date of the person responsible for the provision of services and supervising clinician, if appropriate

CSN's must be completed and placed in the clinical record within 10 business days from the date of rendering the service.

Error Correction

Medical records are legal documents. Providers must be extremely cautious in making alterations to records. In the event that errors are made, adhere to the following guidelines:

- Draw one line through the error and write "error", "ER", "Mistaken Entry", or "ME" to the side of the error in parenthesis. Enter the correction, sign or initial and date it.
- Errors cannot be totally marked through, the information in error must remain legible.
- No correction fluid may be used.

Late Entries

Late entries may be necessary at times to handle omissions in the documentation. Late entries should be rarely used and then only used to correct a genuine error of omission or to add new information that was not discovered until a later date. Whenever late entries are made, adhere to the following guidelines:

- Identify the new entry as “late entry”.
- Enter the current date and time.
- Identify or refer to the date and incident for which the late entry is written.
- If the late entry is used to document an omission, validate the source of additional information as much as possible.
- When using late entries, document as soon as possible.

TUBERCULOSIS (TB) POLICY

Documentation Requirements

All providers must keep documentation in the beneficiary’s medical record to justify medical necessity for the level of service reimbursed, including history, illness, physical findings, diagnosis, laboratory results, radiology results, and records on medications prescribed and delivered. Providers must follow NCCI and coding rules and practices. All services are subject to retrospective review by our Division of Program Integrity.

BREAST CANCER SUSCEPTIBILITY GENE 1 AND 2 (BRCA)

The following documentation must be maintained in the beneficiary’s medical record:

- The HBOC Genetic Testing Prior Authorization Form.
- Pre-testing genetic counseling clinical notes, to include but not limited to the following:
 - Pre-test counseling date with the name and qualifications of the counseling professional.
 - The risks, benefits and limitations discussed with the beneficiary.
 - The beneficiary’s consent to proceed with specific gene mutation testing to be performed as attested by the beneficiary’s signature on the consent form.
- The beneficiary’s BRCA test results.
- Post-testing genetic counseling clinical notes, to include, but not limited to, the following:
 - Post-test counseling date with the name and qualifications of the counseling professional.

- The beneficiary's acknowledgement of the test results.

CHIROPRACTIC SERVICES

As a condition of participation in the South Carolina Medicaid program, providers are required to maintain and allow appropriate access to clinical records that fully disclose the extent of services provided to the Medicaid patient. The maintenance of adequate records is regarded as essential for the delivery of appropriate services and quality medical care.

Providers must be aware that these records are key documents for post-payment review. In the absence of appropriately completed clinical records, previous payments may be recovered by SCDHHS. It is essential for the provider to conduct internal record reviews to ensure that services are medically necessary and that service delivery, documentation, and billing comply with Medicaid policies and procedures.

Clinical Records

Providers are required to maintain a clinical record on each Medicaid patient that includes documentation of all Medicaid-reimbursable services. This documentation must be sufficient to justify Medicaid participation. Clinical records must be current and consistently organized, meet documentation requirements, and provide a clear description of services rendered and progress toward treatment goals. Clinical records should be arranged logically, so that information may be easily reviewed, copied and audited.

Clinical records must be retained for a period of three years. If litigation, claims, or other actions involving the records are initiated prior to the expiration of the three-year period, the records must be retained until completion of the action and resolution of all issues or until the end of the three-year period, whichever is later.

Each Medicaid patient's clinical record must include, at a minimum, the following:

- A Release of Information Form signed by the patient authorizing the release of any medical information necessary to process Medicaid claims and requesting payment of government benefits on behalf of the patient.
- The initial written physician prescription (original or fax) and documentation of subsequent prescriptions required after every third visit.
- Patient history to include the following:
 - A general patient history, including review of systems.
 - Chief complaint/systems causing patient to seek chiropractic treatment.

- Onset and duration of symptomatic problem, which may include quality and character of problem, intensity, frequency, location and radiation, onset, duration, aggravating or relieving factors, prior interventions and treatments, including medications and secondary complaints.
- Family history (if indicated).
- Past health history to include general health statement; prior illnesses, surgical history, prior injuries or traumas, past hospitalizations, medications, allergies, and pregnancies and outcomes.
- A physical examination report to include:
 - Evaluation of the musculoskeletal and nervous system.
 - Evaluation of the cardiovascular and gastrointestinal systems, and of the eye, ear, nose, and throat (both vascular and endocrine), if appropriate to symptoms causing patient to seek chiropractic treatment.
 - Analytical procedures used to determine vertebral subluxation (level and severity) and contraindications to treatment (e.g., inspection, palpation).
- Radiographic film (x-ray) and interpretation.
- A written report/assessment of the patient's condition, including the precise area of subluxation.
- A treatment plan.
- CSNs.

Treatment Plan

If an evaluation indicates that treatment is warranted, the chiropractor must develop and maintain a treatment plan that outlines short- and long-term goals, as well as the recommended scope, frequency and duration of treatment. The treatment plan should serve as a comprehensive plan of care by outlining the service delivery that will address the specific needs of the patient. The treatment plan must be individualized and should specify the problems to be addressed, goals and objectives of treatment, types of interventions to be utilized, planned frequency of service delivery, criteria for achievement, and estimated duration of treatment. The treatment plan must contain the signature and title of the chiropractor and the date signed.

The individualized treatment plan should be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services should be added to the treatment plan. When long-term treatment is required, a new treatment plan must be developed each year. In the event that services are discontinued, the

chiropractor must ensure that the reason for discontinuing treatment is indicated in the treatment plan.

Clinical Service Notes

Chiropractic services must be documented by CSNs. A CSN is a written summary of each treatment session. The purpose of these notes is to record the nature of the patient's treatment by recording the service provided and summarizing the patient's participation in treatment.

CSNs should do the following:

- Furnish a pertinent clinical description of the activities that took place during the session, including an indication of the patient's response to treatment as related to stated goals and objectives.
- Reflect delivery of a specific billable service as identified in the patient's treatment plan.
- Document that the services rendered correspond to billing as to DOS, type of service rendered, and length of time of service delivery.

Error Correction Procedures

The patient's clinical record is a legal document; therefore, extreme caution should be used when altering any part of this record. Appropriate error correction procedures must be followed when correcting an error in the patient's clinical record.

Errors in documentation should never be totally eradicated, and correction fluid should never be used. Draw one line through the error, enter the correction, and add signature (or initials) and date next to the correction. If warranted, an explanation of the correction may be appropriate. In extreme circumstances, having the corrected notation witnessed may be appropriate.

X-Rays

The documenting radiographic film (x-ray) must have been taken at a time reasonably proximate to the initiation of the course of treatment. Unless the chiropractor concludes that more specific x-ray evidence is warranted, an x-ray is considered reasonably proximate if it was taken no more than six months prior to the initiation of a course of chiropractic treatment. Neither an MRI nor CAT scan may be used instead of an x-ray to document subluxation.

The x-ray is required Medicaid documentation and must be maintained in the patient's medical record. X-ray films must have permanent identification of the patient's name, the date the film was taken, and the name of the facility where taken. Films must be marked right or left side. If the x-ray was taken elsewhere (e.g., doctor's office or other medical facility), the written report must be present in the patient's medical record.

PAIN MANAGEMENT SERVICES

Patient records must indicate medical necessity and are subject to post-payment review.

Documentation in the record must indicate the treatment process, which includes the service(s) to be provided, diagnostic procedures and treatment goals. Goals should be specific according to patient needs and the services to be rendered.

Progress summaries must be documented at a minimum of every three months. The summaries must address the patient's progress toward treatment goals, appropriateness of services rendered and recommendations for the continued need for services.

6

BILLING GUIDANCE

SERVICES OUTSIDE OF THE COUNTRY

Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.

DIRECT PHYSICIAN SUPERVISION

For Medicaid billing purposes, direct supervision means that the supervising physician is accessible when the services being billed are provided, and the supervising physician is responsible for all services rendered, fees charged and reimbursements received.

PHYSICIAN'S OFFICE WITHIN AN INSTITUTION

When a physician establishes an office within a nursing home, hospital or other institution, coverage of services and supplies furnished in the office must be determined in accordance with the "incident to a physician's professional services" criteria as determined by federal regulations. A physician's office within an institution must be confined to a separately identified part of the facility that is used solely as the physician's office and cannot be construed to extend throughout the entire institution. Thus, services performed outside the "office" area will be subject to coverage rules applicable to services furnished outside the office setting (i.e., a TC that is included in the institutional reimbursement).

Consideration must be given to the physical proximity of the institution and the physician's office. When his or her office is located within a facility, a physician may not be reimbursed for services, supplies, or use of equipment that falls outside the scope of services "commonly furnished" in physician's offices. Additionally, a distinction must be made between the physician's office practice and the institution, especially when the physician is the administrator or owner of the facility. Thus, for their services to be covered, the auxiliary medical personnel must be members of the office staff rather than of the institution's staff, and the cost of supplies must represent an expense of the physician's office practice. Finally, the physician must directly supervise services performed by the employees of the physician outside the "office" area; his or her presence in the facility as a whole is not sufficient.

PHYSICIAN ADMINISTERED DRUGS

National Drug Code (NDC) Billing Requirements for Drug-Related HCPCS Codes

Medicaid requires providers billing for physician-administered drugs in an office, a clinic, or other OP setting to report the NDC when using a drug-related HCPCS code. The HCPCS code must include the correct NDC 5-4-2 format (11 digits total) to receive reimbursement from Medicaid. The NDC must be used on all claims submission (e.g., electronic, Web Tool and CMS-1500).

Additionally, providers must implement a process to record and maintain the NDC(s) of the drug(s) administered to the beneficiary as well as the quantity of the drug(s) given.

Billing Unlisted/Not Otherwise Specified HCPCS Codes

In addition to documentation detailing the drug that was administered and the medical necessity, providers must also include the product's 11-digit NDC. The claim will suspend for review. Please note that the drug-related procedure code is not payable if the 11-digit NDC is omitted.

NDC Not Found on the NDC to HCPCS Crosswalk

For a drug-related HCPCS code to be reimbursable by SCDHHS, the manufacturer of the drug must participate in the Federal Drug Rebate program. To determine whether the pharmaceutical manufacturer participates in the rebate program, please visit the following website for the NDC/HCPCS crosswalk at <https://www.dmeptac.com/crosswalk/index.html>. The first five digits of the NDC identify the manufacturer of the product. Prescribers should use the crosswalk and the criteria below to determine if the drug is reimbursable by SCDHHS:

- If the first five digits of the 11-digit NDC are listed on the crosswalk, the manufacturer participates in the rebate program and the claim should be submitted to Medicaid. The claim will suspend for review.
- If the first five digits of the 11-digit NDC are not on the crosswalk, the manufacturer does not participate in the rebate program. South Carolina Medicaid does not provide coverage of non-rebated drugs.

Please refer to the Provider Administrative and Billing Manual for information and instructions for claims submission.

TEACHING PHYSICIAN POLICY BILLING REQUIREMENTS

Services provided by residents under the direct supervision of a teaching physician are billable to Medicaid. For Medicaid billing purposes, direct supervision means that the teaching physician is accessible, as defined in Subsection I, when the resident provides the services being billed. The teaching physician is responsible for all services rendered, fees charged and reimbursements received. The services must be documented, as defined in Subsection II, in the patient's medical record. The supervising physician must sign the patient's medical record, indicating that he or she accepts responsibility for the services rendered.

For the purpose of the policy, the following definitions apply:

- **Resident:** A resident is an individual who participates in an approved graduate medical education (GME) program, or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME

programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary.

- **Medical Student:** A medical student is an individual who is enrolled in a program culminating in a degree in medicine. Any contribution of a medical student to the performance of a billable service or procedure must be performed in the physical presence of a teaching physician or jointly with a resident in the course of providing a service meeting the requirements set forth for teaching physician billing.
- **Teaching Physician:** A teaching physician is an individual who, while functioning under the authority and responsibility of a resident program director, involves resident and/or medical students in the care of his or her patients or supervises residents in the care of patients.

RECIPROCAL BILLING AND LOCUM TENENS ARRANGEMENTS

Reciprocal Billing

A physician may submit claims and receive payment for covered visit services (including emergency visits and related services) that the physician arranges to be provided by a substitute physician on an occasional reciprocal basis.

Locum Tenens Arrangements

It is a longstanding and widespread practice for physicians to retain substitute physicians to take over their professional practices when the regular physician is absent for reasons such as illness, pregnancy, vacation or continuing medical education. The regular physician usually bills using his or her Medicaid provider number and receives payment for the substitute physician's services as though the regular physician performed them personally. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than an employee. These substitute physicians are generally called "locum tenens" physicians.

A physician may submit claims and receive payment for covered visit services (including emergency visits and related services) of a locum tenens physician who is not an employee of the regular physician, and whose services for the regular physician's patients are not restricted to the regular physician's office.

The following requirements must be met for both reciprocal billing and locum tenens arrangements:

- The regular physician must be unavailable to provide the visit services.
- The Medicaid beneficiary must have arranged or be seeking to schedule the visit services from the regular physician.
- The substitute physician must meet the same licensing requirements as required by Medicaid. However, Medicaid enrollment is not required.

- The substitute physician cannot provide the visit services to Medicaid beneficiaries over a continuous period of longer than 60 days.
- Claims should be filed using the regular physician's Medicaid Provider ID or NPI number.

The regular physician's office must keep on file a record of each service provided by the substitute physician and make this record available to Medicaid upon request. "Covered visit services" include those services ordinarily characterized as a covered physician visit, as well as any other covered items and services furnished by the substitute physician or by others as incident to the physician services.

EVALUATION AND MANAGEMENT SERVICES

Convenient Care Clinics

CCCs must bill Medicaid using Place of Service Code 17 as defined by the AMA's CPT for a walk-in, retail health clinic. Covered services for this place of service are limited to Episodic Care and wellness/preventative services. Wellness/preventative services are covered for recipients five years and older.

Family Planning Services Referral and Billing

Family Planning beneficiaries have Medicaid coverage for a limited set of medical services. Beneficiaries enrolled in Family Planning are covered for preventive physical examinations and preventive health screenings, but do not have full Medicaid coverage for follow-up visits, treatment or medication (apart from those specifically outlined in the benefit structure).

If a health condition or problem is identified during the physical examination or after the provider receives lab results from a preventive screening that was performed, the provider should refer the patient to a source of free or subsidized care. SCDHHS strongly encourages providers to connect uninsured Family Planning beneficiaries to sources of care such as FQHCs, RHCs, free clinics, subsidized hospital clinics, etc. Providers will be compensated for the administrative costs associated with making referrals for Family Planning beneficiaries.

For more information about where to refer Family Planning patients for follow-up care, please visit the South Carolina Primary Health Care Association website, <http://www.scphca.org/health-centers.aspx> for a listing of all FQHCs in the State or contact the SCDHHS PSC at: +1 888 289 0709.

Instructions

Providers that refer uninsured Family Planning beneficiaries for follow-up care or treatment for a problem or condition identified during the physical examination or annual family planning visit can bill for this referral activity. Providers must use the procedural coding and modifiers listed below. These referral codes may only be used in instances when the follow-up care is not covered as a component of the Family Planning Program.

Note: At least one of the modifiers listed below is required when billing for referral codes.

Note: Providers should NOT use the FP modifier when billing for referral codes.

Providers that refer uninsured Family Planning patients for follow-up care or treatment for any health issue identified during or after (lab results) the physical examination or annual family planning visit may bill for this referral activity using one of the following referral codes:

- Same Day Referral or Telephone Referral: Utilized when a patient is referred to follow-up care immediately after the physical exam or family planning visit OR if lab results are received after the physical exam or family planning visit, and a) results can be explained to the patient by phone and b) referral to follow-up care can occur by phone.
- Different Day Referral (In-Person): Utilized when a patient is required to receive lab results in-person, on a different day than the physical exam or family planning visit occurs.

Billing Instructions

- Providers may include Same Day Referral or Telephone Referral on the same claim form as the physical examination or annual family planning visit.
- Providers may bill for the Same Day Referral or Telephone Referral on a separate claim form. If submitting a separate claim form, diagnosis code Z00.00 or Z00.01 must be used.
- Providers must bill for the in-person, Face-to-Face Referral on a separate claim form. Diagnosis code Z00.00 or Z00.01 must be used.
- Providers must include at least one modifier and up to four modifiers from the list below when billing for both referral codes.

Modifier Instructions

Providers must use the appropriate modifier from the list below. Up to four modifiers can be used for each referral code (e.g., if a patient is referred to follow-up care for more than one positive screening, include modifiers for all positive screenings):

- If referring a patient for a positive diabetes screen, use modifier P1.
- If referring a patient for a positive cardiovascular screen, use modifier P2.
- If referring a patient for any positive cancer screen, use modifier P3.
- If referring a patient for any mental or behavioral health screens, use modifier P4.
- If referring a patient for any other condition or problem, use modifier P5.

Referral Instructions for Family Planning Providers who **do** offer free or subsidized care to uninsured individuals (e.g., FQHCs, hybrid clinics, RHCs, subsidized hospital clinics, etc.).

Providers that offer free or subsidized care to uninsured individuals should schedule follow-up visits with Family Planning beneficiaries when a problem or condition is identified during or after the physical examination or family planning visit. This “self-referral” activity is captured in the encounter rate for the physical examination or family planning visit. However, for data collection and monitoring purposes, providers who fall into this category should include the referral code and appropriate modifiers listed above as a separate line on the Encounter Claim Form (these codes will bill to \$0.00). The referral codes and accompanying modifiers will provide important data to SCDHHS regarding the utilization of follow-up care among the Family Planning population.

Note: Uninsured Family Planning patients will be responsible for any fees associated with follow-up visits. As Family Planning beneficiaries are considered uninsured for purposes of follow-up care, all visits should follow the provider’s established policies and procedures for treating uninsured patients.

Referral Instructions for Family Planning Providers who refer patients for additional, preventive screenings

- If you are a provider that performs a physical examination for a Family Planning beneficiary and are unable to perform certain preventive health screenings (e.g., include mammography, colonoscopy, AAA screening, and lung cancer screening using computerized tomography), you should refer the patient to a provider who is able to perform these screenings.
- Providers are not allowed to submit a referral claim for this type of referral.

Office/Outpatient Exams

After Hour Services

Primary Care Providers (Pediatrician’s, Family Practice, General Practice, Internal Medicine and OB/GYN) may bill the E&M code that best describes the level of service being rendered.

- Services provided in the office at times other than regularly scheduled office hours or days when the office is normally closed (i.e., holidays, Saturday or Sunday), in addition to basic service.
- Service provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.

The purpose of this coverage is to encourage expanded office hours. SCDHHS defines CPT code 99050 to mean all patients scheduled outside published business hours; this would not include a visit that was scheduled at 4:00 pm and the patient was not seen by the physician until 6:30 pm. For CPT code, SCDHHS defines evening hours to be any time after 6:00 pm and before 8:00 am. Weekends are defined as Saturday 8:00 am to Monday 8:00 am. Providers may only bill for the

following holidays, the day of New Year's, Independence, Labor, Thanksgiving and Christmas. Holidays are defined as 8:00 am the morning of the holiday, until 8:00 am the following morning. After-hours procedure codes are not covered when the service is provided in a hospital emergency department, an inpatient setting, OP setting or an urgent care facility (place of service codes 20, 21, 22 and 23). All claims submission could be subject to review by the Department of Program Integrity.

Exceptions to the 977 Edit

Exceptions may be made to this edit under the following criteria:

- SCDHHS has modified the policy regarding ACVs for beneficiaries residing in a nursing home or long-term care facility. Claims with the place of service 31 (SNF), 32 (Nursing Facility), 33 (Custodial Care Facility), and 54 (Intermediate Care Facility/ Intellectually Disabled) will be exempt from the ACV limit of 12 visits.
- A new claim must be submitted within six months of the rejection with a copy of verification of coverage attached indicating ambulatory visits were available for the DOS being billed. The availability of ambulatory visits must have been verified on the actual DOS being billed or the day before.
- If the visit code was a line item rejection and other services paid on the claim, the provider must file a new claim within six months of the rejection with a copy of verification of coverage indicating ambulatory visits were available for the DOS being billed. The availability of ambulatory visits must have been verified on the actual DOS being billed or the day before.
- All timely filing requirements must be met.

A provider has the option to bill the patient for the non-covered office visit only. Medicaid will reimburse lab work, injections, x-rays, etc. done in addition to the office visit.

Another available option is to change the office visit code in field 17 to the minimal established office E&M code, and accept the lower reimbursement. This does not count toward the ambulatory visit limit.

Additional Ambulatory Services

Services commonly rendered in addition to an office exam are compensable if medically necessary. Diagnostic procedures such as lab and x-ray are compensable as separate charges.

Laboratory Services

Diagnostic lab services are compensable as separate charges when the provider actually renders the service and CMS's CLIA certification standards are met. The appropriate lab service must be used.

Special Services/Visits**Post-Operative Follow-up Visit**

This service is non-compensable. Please refer to surgical package guidelines under General Surgery Guidelines within this section of the manual.

Emergency Office Services

Services may be billed in addition to the appropriate level office E&M code when office services are provided on an emergency basis (after posted office hours).

Supplies

Supplies are reimbursable when provided in the physician's office using the following list of procedure codes only. All other supplies are reimbursable through DME providers only.

Major Surgical Tray — Reimbursement may be allowed for a surgical tray when minor surgery is performed in a physician's office that necessitates local anesthesia and other supplies (i.e., gauze, sterile equipment, suturing material, etc.). If the procedure code description includes anesthesia, only the minor surgical tray can be billed. When a major surgical tray is used, local anesthesia cannot be billed separately. Reimbursement will not be provided when a hospital OP department or SNF supplies the tray.

To report, use the appropriate supplemental procedure code for a major surgical tray. A major surgical tray may not be charged for a suture removal tray.

Minor Surgical Tray — A minor surgical tray includes those trays necessary for suture removal, minor debridement, superficial foreign body removal, or incision and drainage of superficial abscess.

Small Supplies and Materials — Used to bill for supplies provided by the physician (except spectacles), which are over and above those usually included with the office visit or other services rendered. This can be used when a starter dose of a one-to-three-day supply purchased by the physician is given to assist in the diagnostic or treatment process. Surgical dressings are compensable if the supplies are medically necessary. Documentation should indicate what supply was used or provided. Charges billed should indicate the actual cost to the physician.

Splints and Casts — These items are reimbursable only under certain circumstances. For details, refer to the musculoskeletal system under the heading Surgical Guidelines for Specific Systems in this section of the manual.

The following additional supplies are listed below:

Lacrimal Puncture Plugs	Pavlik Harness	Contacts, gas permeable, toric/prism, per lens
Indwelling Catheter	Knee Immobilizer, canvas longitudinal	Contacts, hydrophilic, spherical, per lens
Urinary Drainage Bag	Shoulder Immobilizer	Contacts, hydrophilic, toric/ballast, per lens
Urinary Leg Bag	Figure 8 Mobilizer	Anterior Chamber Intraocular Lens
Major Surgical Tray (including anesthetic injection)	Acromioclavicular Brace	Posterior Chamber Intraocular Lens
Splint	Family Planning Condoms	Application of Long Arm Splint
Cast Supplies (e.g., plaster)	Contraceptive Supply, Spermicide (e.g. vaginal foam/cream, suppositories, contraceptive gel/sponge)	Application of Short Arm Splint, static
Special Casting Material (e.g., fiberglass)	Minor Surgical Tray	Application of Short Arm Splint, dynamic
Spacer, bag or reservoir with/without mask	Peak Flow Meter	Application of Finger Splint, static
Sestamibi	Ear Mold, not disposable, any type (use LT or RT modifier)	Application of Finger Splint, dynamic
Supply of Radiopharmaceutical (Technetium)	Ear Mold, disposable, any type (use LT or RT modifier)	Application of Rigid Total Contact Cast
Technetium Medronate (up to 30 mCi)	Zithromax, oral, 1 gram, single dose	Application of Long Leg Splint
Thallous Chloride	Contact Lens, spherical, per lens	Application of Short Leg Splint
Strontium	Contact Lens, toric/prism ballast, per lens	Supplies and Materials
Crutches, wooden, pair		Educational Supplies
Paragard® IUD, cost		
Cervical Collar, flexible, foam	Contacts, gas permeable, spherical, per lens	
Philadelphia Cervical Collar, semi-rigid		

This supply list is not all-inclusive. Some supplies specific to certain specialties may be listed in those sections.

Telemedicine Reimbursement

Professional Services

Reimbursement to the health professional delivering the medical service is the same as the current fee schedule amount for the service provided. Consulting site physicians and practitioners submit claims for telemedicine or telepsychiatry services using the appropriate CPT code for the professional service along with the telemedicine modifier GT, "via interactive audio and video telecommunications system". By coding and billing the "GT" modifier with a covered telemedicine procedure code, the consulting site physician and/or practitioner certifies that the beneficiary was present at originating site when the telemedicine service was furnished. Telemedicine services are subject to copayment requirements. Fee schedules are located on the SCDHHS website at: <http://www.scdhhs.gov>.

Originating Site Facility Fee

The referring site is only eligible to receive a facility fee for telemedicine services. Claims must be submitted with an appropriate HCPCS code (Telemedicine originating site facility fee). If a provider from the referring site performs a separately identifiable service for the beneficiary on the same day as telemedicine, documentation for both services must be clearly and separately identified in the beneficiary's medical record, and both services are eligible for full reimbursement.

FQHCs and RHCs

Referring Site

RHCs and FQHCs are eligible to receive reimbursement for a facility fee for the telemedicine services when operating as the referring site. Claims must be submitted with the HCPCS code for Telemedicine originating site facility fee. When serving as the referring site, the RHCs and FQHCs cannot bill the encounter code if these are the only services being rendered.

Consulting Site

The RHCs and FQHCs would bill an encounter code when operating as the consulting site. Only one encounter code can be billed for a DOS. Both provider types will use the appropriate encounter code for the service along with the "GT" modifier (via interactive audio and video telecommunications system) indicating interactive communication was used.

Hospital Providers

Hospital providers are eligible to receive reimbursement for a facility fee for telemedicine when operating as the referring site. Claims must be submitted with the appropriate telemedicine revenue code. There is no separate reimbursement for telemedicine services when performed during an inpatient stay, OP clinic or ER visit, or OP surgery, as these are all-inclusive payments.

Injections

A list of injection codes is provided on the provider portal. Injection codes include the cost of the drug only, not the administration.

The unit of measure for reimbursement for injectable drugs corresponds to the unit of measure noted in the code description. Indicate the same unit of measure in the “days”/“units” field (24G) on the claim form. For example, if the injection code lists one unit as 50 mg, be sure to indicate 50 mg as one unit. If 100 mg was administered, two units would be indicated on the claim.

Office E&M visits and additional office services are allowed as separate reimbursement from injection codes. If the administration of the drug is the only reason for the visit, then only a minimal established office E&M visit is allowed in addition to the administration code and the drug code. Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular includes the syringe and administration of the drug. Minimal office visits include the observation time, if indicated.

On rare occasions, parenteral medications are provided by someone other than the physician (pharmaceutical company research, patient, etc.). In these cases, the physician may bill South Carolina Medicaid for a minimal office visit if this is the only reason for the visit and providing the service is normally covered.

Note: Beneficiaries are not allowed to use their Medicaid card to obtain non-self-injectable drugs. The reason this practice is not allowed is to prevent a possible duplicate payment from being made by Medicaid (i.e., payment for drug to both the pharmacy provider and to the physician).

Guidelines on allergen immunotherapy can be found under the heading “Allergen and Clinical Immunology” and those for chemotherapy under the heading “Oncology and Hematology” in this section of the manual. Immunization guidelines can be located under the heading “Preventive Care Services”.

Synagis® (Palivizumab)

If a 50 mg vial of Synagis® is administered to an infant up to 2 years old, the appropriate revenue code should be billed in combination with the appropriate service.

SCDHHS has established a 50 mg rate and a 100 mg rate. For multiples of 50 mg dosages (150 mg) or 3 units, SCDHHS will pay the 100 mg price plus the 50 mg price not to exceed 4 units. Therapeutic, prophylactic or diagnostic injections may also be billed for the administration of the drug. Providers must use the dosage that is appropriate for each child according to his or her weight.

In order to ensure consistency, reimbursement for Synagis® is limited to physicians, hospitals and infusion centers. To avoid possible duplicate reimbursement, SCDHHS will not reimburse pharmacy providers for Synagis®. Payment for Synagis® administration will be limited to six doses per RSV season given on or after October 1 and no later than March 31.

Physician-Administered Injectable Drug Reimbursement Methodology

The reimbursement for drugs within each tier is set as follows:

- Tier 1 contains certain generic and injectable drugs in classes with therapeutic alternatives and is priced at Maximum Allowable Cost/Least Cost Alternative.
- Tier 2 contains newer agents and higher cost drugs and is priced at Average Sales Price (ASP) plus 6%.
- Tier 3 contains moderately priced agents and older drugs where there are often significant Average Wholesale Price (AWP)/ASP differences and is priced at ASP plus 10%.
- Tier 4 contains drugs where ASP pricing is not available and is priced at AWP minus 18%.

The SCDHHS will adjust the provider-administered injectable drug fee schedule quarterly so that reimbursement levels reflect changes in market prices for acquiring and administering drugs. Fee schedules are located on the SCDHHS website at: <http://www.scdhhs.gov>.

Cancer Screening Services

South Carolina will sponsor reimbursement for mammography for dually eligible Medicare/Medicaid beneficiaries according to the frequency limitations listed. Claims rejected by Medicare for having exceeded their frequency limitations should be filed with Medicaid on a CMS-1500 claim form with no Medicare information provided.

All services must be physician-generated, and the physician must be currently enrolled in the Medicaid program.

FFS Adult Nutritional Counseling Program

The following billing instructions apply to FFS only. Providers who submit claims to a MCOs should refer to the provider contract with the appropriate MCO for billing instructions.

All providers and dietitians are required to bill with a primary diagnosis code. Secondary diagnosis codes must be in compliance with the ICD-CM and is based on the DOS. All V codes must be billed as secondary diagnosis codes. Z codes must be billed as secondary diagnosis codes.

The following requirements must be met:

- Providers and dietitians must bill utilizing the Adult Nutritional Counseling ICD-10 and HCPCS codes and modifier combinations found on the provider portal.
- Providers may only bill the initial obesity visit on the same day as an E&M service or physical exam. Providers must not bill for subsequent obesity exams on the same day as an E&M service.
- Nutritional counseling units are billed based on a 30-minute session and are limited to one unit per day.

All providers and dietitians are responsible for clearly documenting the patient's chart with all information referenced in this policy. All services provided by both providers and dietitians are subject to review by the Division of Program Integrity. Services not meeting the requirements reflected in this policy may be subject to recoupment by SCDHHS.

Provider Services

The provider can either schedule the patient for an independent visit or may bill the initial obesity visit on the same day as a routine physical exam or E&M service. If the provider chooses to bill for both services on the same day, the provider will need to append the 25 modifier to the billed claim for the second E&M service. Providers may only bill for two E&M services for the initial obesity visit. All obesity visits must be billed utilizing the appropriate HCPCS code. However, for the initial visit, the provider must append a South Carolina modifier.

Subsequent visits may be billed as a one-on-one session between the provider and patient or in a group setting. When billing for a group setting, the provider must append the HB modifier indicating that a group session has been rendered. Group nutritional counseling sessions are limited to a maximum of five patients per group. A claim must be filed for each patient participating in the group sessions. The chart of valid codes and usages is located in the billing requirements section later in the policy.

Dietitian Services

The initial nutritional counseling visit with the dietitian must be billed utilizing the appropriate HCPCS code, defined as a face-to-face, 30-minute session.

All subsequent nutritional counseling must be billed utilizing the appropriate HCPCS code, defined as a one-on-one, 30-minute session between the dietitian and patient or in a group setting. When billing for a group setting, the provider must append the HB modifier and bill for each individual patient. All groups are limited to a maximum of five patients per group.

Adult Physical Exams

Adult physical exams are covered under the following guidelines:

- The exams are allowed once every two years, per patient.
- The patient must be 21 years of age or older.

The following appropriate age and diagnosis code Z00.8 should be used when billing:

- Preventive visit, new, age 18–39
- Preventive visit, new, age 40–64
- Preventive visit, new, age 65+
- Preventive visit, established, 18–39
- Preventive visit, established, 40–64
- Preventive visit, established, 65+

IMMUNIZATIONS

Immunizations for Children

Providers may bill for the administration of vaccines that are obtained through the VFC Program and administered in the doctor's office. When billing for immunization services for children under the age of 19, both the administration code and the vaccine code for the administered vaccine must be listed on the claim to receive reimbursement for the vaccine administration only. For this code combination, only the administration code will be reimbursable.

Immunizations for Adults

When billing for vaccines for beneficiaries 19 years of age and older, the provider should bill for both the vaccine and the immunization administration code. The Rabies, Influenza and Tdap vaccines for adults may be billed through the medical benefit or through the pharmacy. If the pharmacy is billed, then only the administration fee can be billed on the medical side.

Claims submitted for dually eligible patients must first be submitted to Medicare. Covered codes may be found on the Physicians Injectable Drug Fee Schedule located at <https://www.scdhhs.gov>.

PEDIATRICS AND NEONATOLOGY

Routine Newborn Care Exam

This procedure is an all-inclusive code for any visits made during the first day of the newborn's birth.

Routine Newborn Follow-up Care

Follow-up nursery visits made to a healthy newborn on subsequent days are reimbursable. Only one follow-up nursery visit is reimbursed per day regardless of the number of visits made to the nursery.

Newborn Discharged Early

This procedure should be used only to report the history and examination of a normal newborn who is assessed and discharged from the hospital on the day of delivery.

Physicians following a newborn who is discharged before a routine follow-up exam can be performed may bill for the office follow-up exam. This procedure code has a frequency limit of one every 10 months.

Healthy Mothers/Healthy Futures Newborn Health Initiatives

If a physician performs the services listed below in addition to the newborn care exam, Medicaid will provide enhanced reimbursement.

- Mother and infant referral to the WIC program at the county health department (for supplemental food and nutritional counseling).
- Referral to the county health department to set up an infant home visit.

Referral to the county DSS for infant eligibility and an appointment for the first EPSDT well-baby examination.

Newborn Care

The following procedures may also be billed under the newborn's mother's Medicaid number:

- Routine newborn care exam in hospital or birthing center.
- Normal newborn care not in hospital or birthing room setting.
- Follow-up care in nursery for a healthy newborn.
- History and examination.
- Newborn resuscitation.
- Mother/newborn WIC referral.
- Standby for newborn care, limited to two units (e.g., C-section/high-risk delivery).
- E&M Initial comprehensive preventative medicine.

- E&M Periodic Comprehensive Preventative Medicine.

Note: Any other pediatric charges not noted in the above exceptions must be billed under the Child's Medicaid number.

Newborn Care for the Sick Newborn

Used to report the newborn care exam for a sick newborn. If the newborn becomes critically ill, please refer to Neonatology in this section of the manual for coding instructions.

Follow-up Care for the Sick Newborn

Follow-up visits made to a sick newborn may be billed using the appropriate level subsequent hospital care code or critical care code depending on the severity of illness.

Sick Newborn Care Billing Notes

Sick child care may not be billed under the newborn's mother's Medicaid number. Sick child care must be billed under the newborn's Medicaid number.

Sudden Infant Death Syndrome (SIDS)

Appropriate procedure codes should be used to bill for infants being tested for SIDS. They are allowed once and are all-inclusive.

Neonatology

Hospital Care for Sick Newborns

Hospital care for newborns who do not meet the criteria for NICU codes should be billed using hospital care codes or critical care codes, if appropriate.

When the neonate no longer requires the intensity or level of care described in the NICU codes and remains under the care of the same group or physician, subsequent hospital care or critical care codes, if appropriate, may be used. When a neonate is transferred from one hospital to another hospital and remains under the same group or same physician's care, the appropriate level critical care or subsequent hospital care codes may be billed. NICU codes may not be billed if the neonate does not meet the severity of illness or intensity of treatment as defined in the CPT manual.

Newborns Stabilized for Transport

If a physician treats a critically ill newborn in a hospital and stabilizes the newborn for transport to a higher-level hospital appropriate critical care codes may be used for those services. Arterial puncture, withdrawal of blood for diagnosis may not be billed in addition to the critical care. However, arterial catheterization or cannulation for sampling, monitoring or transfusion; percutaneous and catheterization, umbilical artery, newborn, for diagnosis or therapy are allowed in addition to critical care.

Neonatal Intensive Unit Care Codes

Neonatology codes are used to report services provided by a physician directing the inpatient care of a critically ill neonate/infant. Use of these codes must reflect the severity of the neonate's illness, the intensity of treatment, and the level of care as defined in the CPT.

Critical care codes may be used in place of NICU codes when direct physician care is given for an extended period of time exclusively to one neonate. Time must be clearly documented for critical care services.

Additionally, physician standby service and newborn resuscitation are to be used when the physician is standing by for the C-section and newborn resuscitation is required.

Once the neonate is no longer considered to be critically ill, the codes for subsequent hospital care and, when appropriate, subsequent normal newborn hospital care should be used. Initial and subsequent neonatal care includes monitoring and treatment of the patient including nutritional, metabolic, and hematologic maintenance; parent counseling; and personal direct supervision of the health care team in the performance of cognitive and procedural activities.

Initial pediatric critical care, per day — This code reflects initial E&M of a critically ill infant or young child, 29 days up through 24 months of age. This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

If a physician treats a critically ill infant/young child in a hospital and stabilizes the infant/young child for transport to a higher-level hospital, critical care codes would be appropriate for those services. Arterial puncture, withdrawal of blood for diagnosis may not be billed in addition to the critical care. However, arterial catheterization or cannulation for sampling, monitoring or transfusion; percutaneous and catheterization, umbilical artery, newborn, for diagnosis or therapy are allowed in addition to critical care.

The initial NICU code is also allowed for an infant/young child who has been treated for more than one day in one facility and is then transported to another facility for specialized treatment under another group or physician's care. The admitting physician at each facility may report the admission using this code. If the infant/young child is transferred back to the original facility, the appropriate subsequent level of care must be billed since this is considered a continuation of the same hospitalization.

If the neonate is released home and subsequently readmitted to the hospital, NICU codes cannot be billed. You must bill hospital care codes or critical care codes.

Subsequent pediatric critical care, per day — This code reflects subsequent E&M of a critically ill infant or young child, 29 days up through 24 months of age. This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

Initial NICU care, once per physician or group — This code reflects the admission of a critically ill neonate when the intensity of care meets the definition set forth in the CPT. This code is allowed only one time and includes 24 hours of care provided by the attending physician.

Subsequent NICU care, per day — This code reflects subsequent E&M of a critically ill neonate, 28 days of age or less. This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

Subsequent NICU care, per day — This code reflects subsequent E&M of the recovering very low birth weight infant (present body weight less than 1,500 grams). This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

Subsequent NICU care, per day — This code reflects subsequent E&M of the recovering low birth weight infant (present body weight 1,500-2,500 grams). This code is allowed only once per day and includes 24 hours of care provided by the attending physician.

Additional Services

The following services may be billed in addition to the NICU codes. Documentation that the billing physician rendered the services or directly supervised the rendering of the services must be recorded in the medical record. The following list is not a complete list of additional services allowed, but the most frequently billed services only:

- Tracheal Lavage*
- 99255 — SIDS evaluation
- Venipuncture, under age 3 years, femoral, jugular or sagittal sinus*
- Scalp vein*
- Other vein*
- Push transfusion, blood, 2 years or under*
- Exchange transfusion, blood; newborn
- Cut down arterial catheterization*
- Arterial catheterization for prolonged infusion therapy, (chemotherapy), cut down
- Catheterization, umbilical artery, newborn, for diagnosis or therapy*
- Physician Standby Service, requiring prolonged physician attendance, each 30 minutes (limited to two units)**

- Newborn Resuscitation

** These codes are included in the description of the NICU codes in the CPT, however, Medicaid policy has made an exception and these codes may be billed in addition to the NICU codes.*

*** This code is used only for prolonged physician attendance prior to delivery.*

Primary or assistant surgeon charges may be billed in addition to the neonatal or critical care codes.

Extracorporeal Membrane Oxygenation Support (ECMO)

ECMO services are reimbursed by the following CPT codes:

- Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency.
- Prolonged extracorporeal circulation for cardiopulmonary insufficiency, each additional 24 hours.

Prolonged extracorporeal circulation for cardiopulmonary insufficiency will be paid for each additional 24 hours up to four days. However, starting with day five, progress notes should be sent attached to the claim for appropriate reimbursement.

The initial and subsequent NICU care codes may be billed in addition to the ECMO codes.

All other specific CPT surgical procedures that are not included in the 24-hour neonatal codes should be billed separately.

Step Down Neonatal Services

When a neonate is transferred from a Level III hospital to a Level II hospital and remains under the same group or same physician's care, the appropriate level of subsequent, critical care or hospital care codes should be billed depending on the service(s) provided. This coding is also applicable for neonates transferred from the NICU in a hospital to a lower level nursery or unit in the same hospital while remaining under the care of the same group or physician.

Back Transfer of Neonatal Intensive Care Unit Infants

Care must be transferred to another group or another physician's care in order to establish a permanent medical home for these high-risk infants. This coding is also applicable for neonates transferred from the NICU in a level III hospital to a lower level nursery or unit in the same hospital when their care is transferred to another group or physician.

- NICU discharge home visit.

The following six codes can be billed as appropriate, depending on level of care:

- Initial pediatric critical care, per day
- Subsequent pediatric critical care, per day
- Initial NICU care, once per physician or group
- Subsequent NICU care, per day
- Subsequent NICU care, per day, recovering very low birth weight (body weight less than 1,500 grams)
- Subsequent NICU care, per day, recovering low birth weight (body weight 1,500–2,500 grams)

Forensic Medical Evaluations

All forensic evaluations must be medically necessary. Use the following HCPCS codes to bill for these services:

- Prolonged E&M service before and/or after direct (face-to-face) patient care (e.g., review of extensive records and test, communication with other professionals and/or the patient/family); first 30 minutes (list additional minutes separately) for other physician service(s) and/or inpatient or OP E&M service.

Note: this service is used to report the accumulated duration of the time spent by a health care professional providing prolonged care, even if the time spent spans over more than one DOS. (The last DOS should be billed.)

– Each additional 15 minutes (list separately); must be used in conjunction with this service.

- Medical team conference with interdisciplinary team of healthcare professionals, face-to-face with patient and/or family; 15 minutes or more participation by non-physician qualified healthcare professional.

Note: A non-physician qualified health care professional includes, but is not limited to, NPs and PAs.

- Medical team conference with interdisciplinary team of healthcare professionals, without patient and/or family; 15 minutes or more participation by physician.
- Participation by non-physician qualified healthcare professional; 15 minutes or more.

All forensic evaluations must be medically necessary. Only physicians and NPs may bill SCDHHS directly, using their NPI, for services rendered. Registered Nurses (P-SANE) and PAs must bill

using the supervising Physicians NPI number in order to be reimbursed by SCDHHS. Modifiers will indicate which medical professional rendered services. All provider information must be maintained in the patient's records.

FFS Children's Nutritional Counseling Program

The dietitian must bill the initial nutritional counseling visit utilizing medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes. The dietitian may bill a maximum of two units for the initial visit.

All subsequent nutritional counseling visits must be billed utilizing re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes. A subsequent nutritional counseling visit is a one-on-one session with the patient or a session between the dietitian and patient in a group setting. The dietitian may bill 30-minute sessions, if medically necessary, which means that the dietitian would bill a maximum of two units in a day and a maximum of 10 units within a year. When billing for nutritional counseling in a group setting, the dietitian must append the HB modifier (adult program, non-geriatric) to the HCPCS code. Group nutritional counseling sessions are limited to a maximum of five patients per group.

Billing Requirements

All providers and dietitians are required to bill with a primary diagnosis code. Secondary diagnosis codes must be in compliance with the ICD-CM and is based on the DOS. Z codes must be billed as secondary diagnosis codes.

The following requirements must be met:

- Providers and dietitians must bill utilizing the Children's Nutritional Counseling ICD-10 and CPT/HCPCS codes and modifier combinations found on the provider portal.
- Providers must not bill for initial or subsequent obesity exams on the same day as an E&M service.
- Providers may bill subsequent visits with one-on-one counseling or group counseling by appending the HB modifier to the E&M service.
- Nutritional counseling units billed are based on a 15-minute session and are limited to two units per day, with a maximum of 12 units in a year.

Providers and dietitians are responsible for clearly documenting the child's chart with all information referenced in this policy. All services rendered by both providers and dietitians are subject to review by the Division of Program Integrity. Services not meeting the requirements reflected in this policy may be subject to recoupment by SCDHHS.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Providers can bill for EPSDT services and immunizations on the CMS-1500 claim form using the appropriate CPT codes. Providers who are set up for electronic billing may bill using the electronic billing system when using these CPT codes. Providers using the CMS-1500 claim form must bill under the Medicaid provider numbers they currently use for billing on the claim form such as:

- Physicians must bill under their group or individual provider numbers.
- Clinics must bill under their clinic numbers.
- RHCs must bill under their RHC provider number.
- FQHCs must bill under their FQHC provider number.

Providers using the CMS-1500 will be responsible for handling their own EPSDT scheduling for patients in their practice.

Periodic and Interperiodic Screening Services

- All EPSDT screenings must be billed using the appropriate CPT codes regardless of provider type or location.
- Prior authorizations are NOT required for Periodic or Interperiodic screening services.
- For FQHCs and RHCs, an EPSDT screening is considered an encounter; however, the appropriate CPT screening codes must be billed for reimbursement. A screening and an encounter code may not be billed on the same DOS.
- Medicaid providers enrolled with SCDHEC in the VFC program may bill an immunization administration fee.

The following indicators must be used in field 24H of the CMS-1500 claim form when billing a screening:

Indicator 1 — Well-child care with treatment of an identified problem treated by the physician

Indicator 2 — Well-child care with a referral made for an identified problem to another provider

Indicator N — No problems found during visit

Medically Necessary Services

Providers must bill using the appropriate diagnosis and treatment code for each procedure. Providers must obtain a prior authorization for all medically necessary non-State Plan EPSDT services; submitting documentation of medical necessity and any additional information will assist in this determination.

Reimbursement for EPSDT Services

Note: This policy applies only to the Physician's office and CCCs. For reimbursement in FQHCs and RHCs, please refer to the respective sections of this manual.

EPSDT Periodic Screening

EPSDT periodic screenings will be reimbursed at a uniform rate. Although screening services vary according to age and schedule, the reimbursement is intended to be an equitable average fee. Any other test or treatment service performed should be billed separately. For FQHC and RHC facilities, the screening reimbursement rate is the facility's established contract daily rate. The following guidelines should be used when billing for periodic screening:

- Screening components cannot be fragmented and billed separately.
- The screening provider cannot bill an office visit on the same day a screening is billed.
- South Carolina Medicaid policy allows providers to bill an EPSDT well-child screening on the same day as a sick visit.
- If individual components of a screening are not performed, the reason must be appropriately documented. Reimbursement for the screening fee may be subject to recoupment if each age-appropriate component is not performed and not documented.

EPSDT Interperiodic Screening

Reimbursement for an interperiodic screening is the same as a periodic screening. The following guidelines should be used when billing for interperiodic screenings:

- The provider must indicate the diagnosis code of the condition to justify the medical necessity for performing an interperiodic screening.
- The interperiodic screening must include all the required screening components appropriate to the child's age.
- Individual screening components or follow-up treatment cannot be billed as an interperiodic screening.

Additional Services

Additional services performed during an EPSDT visit may be covered separately from the EPSDT visit utilizing the appropriate CPT code and billed at a frequency according to the periodicity schedule available at: <https://www.scdhhs.gov/press-release/medicaid-periodicity-schedule>. The additional services include:

- Immunization Administration:

- When billing for an immunization administration and an EPSDT examination code on the same day, the provider must use modifier XU when billing the immunization administrative code in order to receive additional reimbursement.
- Providers may bill for the administration of vaccines that are obtained through the VFC Program and administered in the physician's office.
- When billing for immunization services for children under the age of 19, both the administration code and the vaccine code for the administered vaccine must be listed on the claim to receive reimbursement for the vaccine administration only. For this code combination, only the administration code will be reimbursable.
- Topical Fluoride Varnish
- Laboratory Tests and Analysis:
 - Reimbursement for the lab analysis is not part of the EPSDT service rate.
 - Blood level assessments:
 - › If the provider office sends the blood lead samples to an outside laboratory for analysis, the laboratory will bill Medicaid directly for the blood lead analysis.
 - › If the provider office is using the ESA LeadCare Blood Lead Testing System to analyze the blood lead samples internally, then the office should bill Medicaid directly using.
 - Age Limited Screenings
 - Elective Tests
 - Developmental and Behavioral Assessments

EPSDT providers are allowed to bill for standardized developmental, mental, emotional, behavioral and psychosocial assessments utilizing standardized screening tools that are culturally sensitive and have a moderate to high sensitivity, specificity and validity level. A general screening is recommended with follow-up screening, as indicated. Documentation must include a copy of the completed screening tool and the score per instrument screening tool. Billing for screenings follow coding guidelines and NCCI edits.

- Childhood and Adolescent Developmental Levels:
 - This code is limited to a frequency of two times per day for beneficiaries up to 18 years of age. Examples of standardized screening instruments include, but are not limited to:

- › Ages and Stages Questionnaire, 3rd Edition (ASQ)
- › Parents Evaluation of Developmental Status (PEDS)
- › Modified Checklist of Autism in Toddlers (MCHAT)
- Emotional and/or Behavioral Health Assessment:
 - This code is limited to a frequency of two times per day for beneficiaries up to 18 years of age. Examples of standardized screening instruments include, but are not limited to:
 - › Ages and Stages Questionnaire: Social-Emotional (ASQ: SE)
 - › Pediatric Symptom Checklist (PSC) or Pediatric Symptom Checklist — Youth Report (PSC-Y)
 - › Modified Patient Health Questionnaire (PHQ-9)
 - › Screen for Child Anxiety Related Emotional Disorders (SCARED)
 - › Vanderbilt Diagnostic Rating Scale (Vanderbilt)
- Patient Focused Health Risk Assessment (e.g., health hazard appraisal). This code is limited to a frequency of two times per day for beneficiaries through 18 years of age. Examples of standardized screening instruments include, but are not limited to:
 - Acute Concussion Evaluation (ACE)
 - CRAFFT Screening Interview
 - Guidelines for Adolescent Preventative Services (GAPS)
- Caregiver-Focused Health Risk Assessment (e.g., depression inventory) for the benefit of the patient. This code is limited to a frequency of two times per DOS. Examples of standardized screening instruments include, but are not limited to:
 - Edinburgh Maternal Depression Screen
 - Safe Environment for Every Kid (SEEK)

TOBACCO CESSATION

Counseling

Tobacco cessation counseling in individual and group settings are covered when billed with appropriate CPT codes. Reimbursement for counseling is limited to four sessions per quit attempt for up to two quit attempts annually. Tobacco cessation counseling may be billed on the same day as an office visit using a 25 modifier.

OBSTETRICS AND GYNECOLOGY

Initial OB Exam

A higher-level E&M code may be billed for OB visits other than those outlined in the manual; however, the visit must meet CPT guidelines for level of complexity and be documented in the patient's chart.

Only one initial OB exam may be billed per pregnancy.

Initial OB Exam HM/HF OB Program — An initial OB exam may be billed one time during a term of pregnancy. Requirements for the use of this HM/HF code are:

- Comprehensive medical exam.
- Establishment of the patient's medical history.
- Provision of health education materials.
- WIC referral to the local county health department.

The WIC referral can be made at a later date since the provider may not be aware that a patient has Medicaid benefits until later in her pregnancy. The WIC referral must be documented in the patient's chart.

Initial OB Exam without Enhanced Services — Use of this code has the same requirement as the HM/HF code, except that a WIC referral is not required.

Screening Brief Intervention and Referral to Treatment Initiative

The following billing procedures must be utilized in order to receive payment for SBIRT services.

SCDHHS began coverage for SBIRT in 2011 to improve birth outcomes and the overall health of moms and babies. SCDHHS has partnered with stakeholders across the state to help identify and treat pregnant beneficiaries who may experience alcohol or other substance abuse issues, depression, tobacco use or domestic violence. SBIRT services (screening and, when applicable, a brief intervention) are reimbursable in addition to an E&M code for pregnant women and/or those who are in the 12-month postpartum period.

SCDHHS will continue to use the screening and intervention HCPCS codes. The HD modifier is required when the services rendered indicate a positive result and/or when a referral is completed.

Providers must use the appropriate HCPCS code and the HD modifier when an SBIRT screening result is positive. Additionally, providers must use the appropriate HCPCS code with the HD modifier when a referral to treatment is made in conjunction with the brief intervention. These changes in billing procedures apply for Healthy Connections Medicaid members enrolled in both the Medicaid FFS and Medicaid Managed Care program.

- Screening — once per fiscal year
- Brief Intervention — twice per fiscal year

The Institute for Health and Recovery's Integrated Screening Tool, which is a validated and objective resource, must be used to receive reimbursement for screening and intervention. A copy of this screening tool is located in the Forms section of the Provider Administrative and Billing Manual.

When billing for SBIRT services using appropriate HCPCS codes, providers must bill using both their individual and group NPI numbers on the CMS-1500 form or an electronic claim.

Antepartum Visits

South Carolina Medicaid provides pregnant women with unlimited antepartum ACVs, and recognizes E&M procedure codes as antepartum visits when billed in conjunction with a pregnancy diagnosis code. To ensure that the E&M codes billed for antepartum care do not count towards the patient's limit of 12 ACVs per year, a pregnancy diagnosis code must be used on the claim.

Please refer to the information regarding ICD-10-CM pregnancy diagnosis codes on the provider portal.

Antepartum Visits with Additional Services — Antepartum care includes continuing physical exams and recording of weight, blood pressure and fetal tones. The additional services necessary for use of this enhanced antepartum code include:

- Follow-up on referrals.
- Follow-up on missed appointments.
- Continued health education.

The enhanced services may be documented by a notation in the woman's chart on each visit, or by dating the HM/HF checklist for the topic covered each visit. Use of the HM/HF checklist is optional.

A sample copy of the checklist can be found in the Forms section of the Provider and Administrative Manual.

Antepartum Visits without Additional Services — Use of the antepartum visit procedure code must include continuing physical exams, recording of weight, blood pressure and fetal tones.

Antepartum Visits with “Higher than Usual” Level of Care — If appropriate due to the level of care, a higher-level E&M code may be billed for the antepartum visit. Documentation must justify the level of care.

17 Alpha Hydroxyprogesterone Caproate (Makena® and 17P)

Providers must bill the HCPCS code for Injection, hydroxyprogesterone caproate, (Makena®), 10 mg and/or Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg and bill for the appropriate amount of units administered. Providers billing for compounded 17 alpha hydroxyprogesterone caproate will continue to bill the appropriate HCPCS code using the TH modifier (obstetrical treatment/services, prenatal or postpartum) in order to be reimbursed. When billing for Makena® or Compounded 17-P, the appropriate CPT code can be billed for administration of the drug, which must be given in the physician’s office or clinic. The reimbursement for Makena® (injection, hydroxyprogesterone caproate (Makena®), 10 mg) and/or injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg is listed on our Other Physician’s Fee Schedule at www.scdhhs.gov. When billing Medicaid, providers must include the NDC in field 24A of the CMS-1500 claim form and the number of units in field 24G.

All providers must keep documentation showing the medical necessity for either Makena® or 17-P in the patient’s chart. All claims are subject to potential PI audits and therefore, it is the provider’s responsibility to maintain the patient’s records.

Multiple Births

For multiple births of more than two, the claim should be sent hardcopy with operative notes attached.

If the patient delivers multiple babies, all either vaginally or by C-section, the first birth should be billed with no modifier, and each consecutive birth should be billed using modifier 51.

Example: Delivery of triplets, all vaginally:

(00) Vaginal Delivery

(51) Vaginal Delivery

(51) Vaginal Delivery

If the patient delivers multiple babies, the first vaginally and one (or more) via C-section, the first birth should be billed with no modifier, and the following birth, via C-section, should be billed using modifier 79.

Example: Delivery of triplets, 1st birth vaginally, 2nd and 3rd via C-Section:

(00) Vaginal Delivery

(79) C-section Delivery

(51) C-section Delivery

If you should have further questions regarding multiple births, please contact PSC at: +1 888 289 0709 or submit an online inquiry at: <http://www.scdhhs.gov/contact-us>.

Abortion

When billing for any type of abortion, the procedures must be billed using the abortion procedure codes. There are separate codes for spontaneous, missed, and septic abortions, and hydatidiform mole; and for therapeutic abortion. The vaginal delivery code should not be used to report an abortion procedure.

The only exception to this rule is if the physician actually performs the delivery of the fetus and only when the gestation is questionable and there is a probability of survival. The medical record must contain documented evidence that the fetus was delivered by the physician. If the physician did not perform the delivery, but problems necessitated his or her presence, then the appropriate E&M codes should be used to report these services.

Diagnosis codes to be used only to report therapeutic abortions and diagnosis codes to be used to report spontaneous, inevitable and missed abortions. Please refer to the provider portal for ICD-10-CM diagnosis codes for these services. Abortions, which are reported with diagnosis and procedure codes for therapeutic abortion, must be accompanied by complete medical records which substantiate life endangerment to the mother or that the pregnancy is a result of rape or incest, and the signed abortion statement.

Please refer to the provider portal for diagnosis codes do not require documentation.

Licensed Midwife

Required Modifier for Licensed Midwives

When filing claims for services rendered by licensed midwives, all procedure codes must be filed with an SB modifier.

Initial OB Exam by the Licensed Midwife

The initial obstetrical exam by the Licensed Midwife must be billed using the appropriate level of E&M CPT procedure code for the complexity of the exam. An initial OB exam may be billed one time only during the term of pregnancy. An exam billed using this procedure code must meet the following requirements:

- Must be a comprehensive medical exam.
- Must establish the patient's medical history.
- Must provide health education materials.
- Must include a WIC referral to the local county health department. (This referral can be made at a later date since the provider may not be aware that a patient has Medicaid benefits until later in her pregnancy; the WIC referral must be documented in the patient's chart.)

Physician Back-up Coding

Each of the two obstetrical examinations by the back-up physician must be billed using the appropriate level of complexity E&M CPT procedure code.

Delivery Supply Code

An additional code has been developed to reimburse for supplies used for delivery in the home setting. This procedure code may be billed by the Licensed Midwife in addition to the vaginal delivery code.

Newborn Care

The newborn examination should be billed with this CPT code using the SB modifier.

Newborn Metabolic Screening

In compliance with SCDHEC Newborn Screening regulations, if there is no attending physician, then the Licensed Midwife is responsible for the collection of specimens. This procedure code may be billed by the Licensed Midwife when an invoice has been sent to them from SCDHEC for the service. The invoice must be maintained in the medical records.

Hysterectomies

Reimbursement for a hysterectomy is not allowed if the hysterectomy is performed solely for the purpose of rendering an individual permanently incapable of reproducing. A hysterectomy may not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

A hysterectomy can be reimbursed by Medicaid in cases of retroactive eligibility only if the physician certifies in writing ONE of the following:

- The individual was already sterile before the hysterectomy and the physician who performs the hysterectomy certified in writing that the individual was sterile at the time of the hysterectomy. The certification must state the cause of the sterility.
- The individual requires a hysterectomy because of a life-threatening emergency situation, and the physician who performs the hysterectomy certified in writing that the hysterectomy was performed under a life-threatening situation in which the physician determined prior acknowledgement was not possible. The certification must include a diagnosis and description of the nature of the emergency. If timing permits, prior approval may be requested, but appropriate and timely medical care should not be delayed to obtain this approval.

Ectopic Pregnancy

For surgical treatment of an ectopic pregnancy, bill the appropriate code. No documentation is required with the claim when using these codes.

Pelvic Exam

A pelvic exam under anesthesia should only be billed if performed separately and if medically indicated. Pelvic exams at the time of surgery involving the vagina or through a vaginal incision are included in the surgical procedure and should not be billed in addition to the surgical procedure (e.g., vaginal hysterectomy, laparoscopic elective sterilization, conization of the cervix, etc.).

Sterilization and Other Related Procedures

Under the following circumstances, bill the corresponding sterilization procedure codes:

Essure® Sterilization Procedure

Effective with dates of service prior to May 31, 2010, SCDHHS will reimburse for the Essure® Sterilization procedure only when certain criteria are met. This procedure is available to women who have risk factors that prevent a physician from performing a safe and effective laparoscopic tubal ligation. Reimbursement will be provided for any of the following criteria:

- Morbid obesity (BMI of 35 or greater).
- Abdominal mesh that mechanically interferes with the laparoscopic tubal ligation.
- Permanent colostomy.
- Multiple abdominal/pelvic surgeries with documented severe adhesions.
- Artificial heart valve requiring continuous anticoagulation.

- Any severe medical problems that would contraindicate laparoscopy because of anesthesia considerations. (This must be attested in the request for prior approval that general anesthesia would pose a substantial threat to the beneficiary's life.)

The procedure will be covered when performed in an inpatient or OP hospital setting or in a physician's office. SCDHHS will reimburse the implantable device by utilizing the HCPCS code with the FP modifier, and the professional service will be reimbursed utilizing the CPT code with the FP modifier.

Hysterosalpingogram and Radiological Supervision and Interpretation should be billed as follow-up procedures 90 days after the sterilization. A Sterilization Consent form must be completed and submitted with the claim.

Federal guidelines for sterilization procedures will remain a requirement which includes completing and submitting a Sterilization Consent Form.

- Tubal ligation following a vaginal delivery by a method except laparoscope.
- Tubal ligation following C- section or other intra-abdominal (tubal ligation as the minor procedure) surgery.
- Ligation, transection of fallopian tubes; abdominal or vaginal approach.
- Occlusion of fallopian tubes by device.
- Laparoscopic sterilization by fulguration or cauterization.
- Laparoscopic sterilization by occlusion by device.
- Vasectomy.

When billing for a vaginal delivery as well as a tubal ligation performed on the same DOS, the tubal ligation must be billed using modifier 79 (unrelated procedure or service by the same physician or other qualified health care professional during the post-operative period) to ensure proper reimbursement.

Claims for sterilization services should always be billed hardcopy with a copy of the Sterilization Consent Form attached.

Salpingectomy and/or Oophorectomy — The operative report must be submitted with the claim. The medical record must reflect medical necessity for the procedure performed. Reimbursement using these codes is not allowed if performed as a sterilization procedure, unless a copy of the Sterilization Consent Form is attached.

Dilation and Curettage — When a D&C is performed at the same time as sterilization, medical necessity for the D&C must be clearly documented in the patient's operative report.

PSYCHIATRIC AND COUNSELING SERVICES

Additional Billable Codes

Additional codes may be billed by a physician specializing in psychiatric care.

Pediatric Sub-Specialist Program

SCDHHS will reimburse an enhanced rate to certain pediatric sub-specialists that meet the enrollment requirements. Please refer to The Pediatric Sub-Specialist Program under Special Coverage Groups in this section of the manual for full eligibility criteria to participate in this program.

NEPHROLOGY AND END STAGE RENAL DISEASE SERVICES

Physician-related Dialysis Procedures

In-Center Dialysis — Medicaid reimburses the nephrologist or other supervising internist an all-inclusive monthly fee for the supervision of ESRD services. These services are defined as monthly supervision of medical care, dietetic services, social services and procedures directly related to the physician's role in the treatment of ESRD.

If billing for a complete month of treatment supervision, the monthly code should be used. The DOS should be the last date in the month and the "days" unit block should be a "one", indicating one full month of supervision.

The monthly ESRD code includes all services rendered to the patient for all days of the month. Office visits should not be billed in addition to the monthly supervision. Special procedures may be billed separately (e.g., shunt revision, cannula declogging).

If the patient is hospitalized, or for some reason did not have a full month of in-center treatments, the partial month procedure code should be used with the appropriate number of days of supervision in the days/unit column on the CMS-1500 claim form and the appropriate "to" and "from" dates of service.

Inpatient Dialysis — If an ESRD patient is hospitalized, the hospitalization may or may not be due to a renal-related condition. In either case, the patient must continue dialysis.

Inpatient dialysis usually requires more intense physician involvement for a prolonged period and/or multiple visits. Physicians will be reimbursed for inpatient dialysis services to either acute renal failure (ARF) or ESRD patients on a FFS basis. Guidelines are the same for inpatient dialysis whether the patient is ARF or ESRD.

Complications or hospitalization for reasons not related to dialysis or the treatment of dialysis may be charged separately. However, when dialysis codes are charged, hospital visits may not be charged for the same DOS.

Visits may be charged on alternate dialysis days when applicable. Special procedures (e.g., an EKG) may be charged when clearly justified as a service outside of the normal dialysis management.

For inpatient dialysis, services Medicaid will apply the same rules as it does for all reasonable charge determinations. The services must meet the following criteria:

- They must be covered physician services.
- They must be medically necessary.
- They must be personally furnished by the physician.
- They must be within the requirements under Part B Medicare.

Home Dialysis — Medicare is the primary sponsor for patients receiving home dialysis services and Medicaid, if available, is the secondary sponsor of coinsurance and deductibles. The Social Security Administration does not require a delayed period for home services, and Medicare will reimburse from the initial course of treatment.

In this case, Medicaid will not reimburse for home treatments during the first ninety days of services as primary sponsor, but will pay coinsurance and deductibles.

In certain instances, where Medicaid is the primary sponsor, the physician supervising the home dialysis patient should adhere to policies for in-center supervision. Reimbursement will be per full month of supervision, or per day for partial months. The monthly supervision fee includes all the services outlined for the alternate method of reimbursement. A home training supervision fee is allowed for the first month of home dialysis in addition to the regular monthly fee for treatment supervision.

Dialysis Training — Dialysis training is a covered service for ESRD patients. The initial completed course and per training session should be billed for training services for any mode (self, peritoneal or hemodialysis). The initial course is allowed only once in a lifetime. Training services for self-dialysis performed after the initial course is completed (retraining) are compensable on a per day basis, and under the following Medicare guidelines:

- The patient changes from one mode of dialysis to another.
- The patient's home dialysis equipment changes.
- The patient's dialysis setting changes.
- The patient's dialysis partner changes.

- The patient's medical condition changes (the patient must continue to be an appropriate patient for self-dialysis).

Home support services (e.g., reviewing the patient's technique and instructing him or her in any corrections) are not compensable as training services. Support services are included in the monthly or partial month ESRD supervision fees.

PART II — DIAGNOSTIC OPHTHALMOLOGY SERVICES

Diagnostic services included in the CPT coding range 92018-92287 are compensable as separate procedures if performed as a distinct and individual service and not included in the ophthalmological or E&M exam, with the following restrictions:

Cardiology

Cardiac Catheterization

The cardiologist must bill for the catheterization that describes the procedure and technique utilized; fragmenting the codes is not allowed.

If medically indicated, intracardiac electrophysiological procedures may be billed in addition to the catheterization angiogram procedure.

Cardiac MRI of the heart procedure codes are used to report the physician's attendance and participation in the MRI of the heart. When filing for this procedure, bill appropriate MRI code depending on level of service. Use modifier 26 when billing the professional component only. The technical portion will be reimbursed to the hospital under the revenue code for MRI. Medical necessity for both the MRI and heart catheter (if needed) must be documented in the beneficiary's chart. The procedure should be performed in lieu of heart catheterization, when possible. The code will be allowed reimbursement only once per DOS, regardless of how many sessions or images are performed.

Vascular Studies

Reimbursement to a provider for services purchased from an outside supplier or lab is not allowed. Reimbursement is only allowed to the provider who performed the service and is enrolled with South Carolina Medicaid.

Independent physiology labs performing monitoring services must be enrolled for participation. The physician requesting the service may only bill for the interpretation of the study if performed.

Oncology and Hematology

Infusion start and stop time should be clearly documented. Start time does not include the E&M service or delivery of adjunctive therapy by a nurse or physician.

Chemotherapy administrations, push technique, are only for pushing a chemotherapy agent and are not to be billed when pushing pre-medications or providing other incidental services. Only one push

technique code will be allowed per day. These codes cannot be billed when given in a hospital setting.

If routine maintenance (flushing with heparin and saline) of an access device is the only service rendered, and is rendered by the nurse, the office visit code is appropriate.

Therapeutic or diagnostic infusions codes should only be billed when a therapeutic or diagnostic agent other than chemotherapy must be infused over an extended period of time. Payment of these codes is considered bundled into the payment for chemotherapy infusion when administered simultaneously. Separate payment is allowed when these services are administered sequentially or as a separate procedure. These codes cannot be billed in a hospital setting or in addition to prolonged service codes.

Blood transfusions may be billed only when the physician or an employee of the physician actually performs the transfusion. It should be billed per unit of blood. If the transfusion requires prolonged physician attendance, then it is appropriate to charge for this service. The medical record must substantiate this service. If hospital personnel administer the blood transfusion, it is reimbursable only under the hospital allowable costs.

A listing of chemotherapy drug codes can be found on the provider portal. The codes include the cost of the drug only, not the administration. Chemotherapy agents provided by a hospital are considered a technical cost and may not be charged by a physician. The hospital is reimbursed for all technical costs.

When a patient receives the entire regimen of chemotherapy in an office setting, including lab work, hydration, pre-medication and all chemotherapy agents, these procedures indicate an infusion or injection by the physician or an employee of the physician. The following are appropriate codes to bill:

- If the patient received chemotherapy over four hours in the office via IV infusion:
 - Chemotherapy administration, intravenous infusion technique; up to an hour, single or initial substance/drug
 - Each additional hour, 1 to 8 hours
 - J Codes — Appropriate medication charges
- E&M services are allowed when a separate and identifiable medical necessity exists and is clearly documented in the patient's chart. The physician should not routinely bill an E&M service for every patient prior to chemotherapy administration. Only one E&M service is billable per patient per day.

- Prolonged services may be billed in addition to the E&M code when there is more than an hour of actual face-to-face physician time required beyond the usual service for the level of the E&M code billed. This code should only be used when the physician's expertise is medically necessary in evaluating and managing the patient over a prolonged period and specific documentation describes the content and duration of the service.
- Critical care services should only be used in situations requiring constant physician attendance of an unstable or critically ill patient. These codes should only be used in situations significantly more complex than other chemotherapy situations.

Inpatient and Outpatient Hospital Services

Services or supplies administered by the hospital or hospital employees are considered a part of the overall hospital service and are reimbursable only under the hospital allowable costs. A physician who is either salaried or contracted by the hospital, and who performs services under contract or employment, may not bill for those services separately under his or her individual Medicaid provider number. The contracting hospital may claim these services under the professional fees allowable for the hospital under their hospital-based physician Medicaid number.

Gastroenterology

Gastrostomy Button Device Feeding Tube Kit

Claims must be processed on a CMS-1500 claim form and include a copy of the invoice and appropriate documentation supporting the medical necessity of the device.

Physical Medicine and Therapy

Osteopathic Manipulative Treatment

An E&M office code may be billed in addition to an OMT code if the E&M service performed is documented as a significant, separately identifiable service.

Breast Cancer Susceptibility Gene 1 and 2 (BRCA)

The following services are covered for BRCA genetic testing and genetic counseling:

- BRCA1, BRCA2 gene analysis; full sequence analysis and full duplication/deletion analysis (i.e., detection of large gene rearrangements)
- BRCA1, BRCA2 gene analysis; full sequence analysis
- BRCA1, BRCA2 gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)
- BRCA1, gene analysis; full sequence analysis
- BRCA1 gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)

- BRCA2 gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)
- BRCA1, BRCA2 gene analysis; 185delAG, 5385insC, 6174delT variants
- BRCA1 gene analysis; known familial variant
- BRCA2 gene analysis; full sequence analysis
- BRCA2 gene analysis; known familial variant
- Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family
- Genetic counseling, under physician supervision, each 15 minutes

Chiropractic Services

Billing for CMT is limited to one procedure per visit and one visit per day, with a maximum of six visits during a state fiscal year (July 1–June 30), with no exceptions. Eligible Medicaid beneficiaries, regardless of age, will be allowed six chiropractic visits per state fiscal year providers must call the toll-free telephone number on the back of the Medicaid insurance card to verify a patient's current eligibility and number of visits used to date during the current state fiscal year. Visits not used in one year do not carry over to the next year.

Note: For dually eligible Medicaid and Medicare beneficiaries, Medicare is the primary payer. Bill all chiropractic services to Medicare first. Once a dually eligible beneficiary has exhausted his or her Medicare-allowed chiropractic services, Medicaid reimbursement for chiropractic services is no longer available.

Medicaid-reimbursable CMT services are limited to the following three services only:

- CMT; Spinal, 1 to 2 Regions
- CMT; Spinal, 3 to 4 Regions
- CMT; Spinal, 5 Regions

Radiologic Examination (X-Ray)

Billing for radiologic examination is limited to two x-rays per beneficiary per state fiscal year (July 1–June 30). Medicaid-reimbursable radiology services are limited to the following:

- Radiologic Examination; Spine, Entire, Survey Study; Anteroposterior and Lateral
- Radiologic Examination; Spine, Cervical; Anteroposterior and Lateral

- Radiologic Examination; Spine, Thoracic; Anteroposterior and Lateral
- Radiologic Examination; Spine, Thorocolumbar; Anteroposterior and Lateral
- Radiologic Examination; Spine, Lumbosacral; Anteroposterior and Lateral

HYPERBARIC OXYGEN THERAPY

Technical Component

All technical services must be billed on the UB-04 hospital claim form. Payment for OP hyperbaric therapy is allowed. Inpatient therapy cannot be billed separately as the fee is included in the hospital DRG or per diem rate.

Professional Component

If a physician directly supervises the HBO therapy, procedure codes for HBO may be billed on the CMS-1500 claim form; no modifier is necessary. The professional component should be coded as one of the following:

- Initial Treatment — An initial treatment is compensable only once per course of treatment for a specific diagnosis. HBO initial treatment is not billed in units of time, but rather the first day of the initial therapy.
- Subsequent Care — All subsequent HBO therapy treatments must be coded as such. Subsequent therapy is defined as any length of therapy following the initial treatment on any given day. If two subsequent treatments are performed on the same DOS (at different times of the day), a second charge may be used with a 76 modifier. HBO therapy is not billed in units of time, but rather in episodes of treatment.

GENERAL SURGERY GUIDELINES

Hospital Acquired Conditions (HACs)

SCDHHS will make zero payments to providers for other provider preventable conditions which includes Never Events. The reporting requirements for Never Events include ASCs and practitioners. These providers will be required to report Never Events on the CMS-1500 claim form or the 837-P claim transaction. Avoidable errors that fall under this policy include:

- Wrong surgical or other invasive procedure performed on a patient.
- Surgery or other invasive procedure on the wrong body part.
- Surgical or other invasive procedure performed on the wrong patient.

Providers are required to follow the following procedures for reporting avoidable errors (Never Events):

Claims submitted using the CMS-1500 claim form or 837-P claim transaction, must include the appropriate modifier appended to all lines that relate to the erroneous surgery(s) or procedure(s) using one of the following applicable National Coverage Determination modifiers:

- PA — Surgery wrong body part
- PB — Surgery wrong patient
- PC — Wrong surgery on patient

The non-covered claim must also include one of the following ICD-10-CM diagnosis codes reported:

- Y65.51 — Performance of wrong procedure (operation) on correct patient
- Y65.52 — Performance of procedure (operation) on patient not scheduled for surgery
- Y65.53 — Performance of correct procedure (operation) on wrong side or body part

Related Claims

Within 30 days of receiving a claim for a surgical error, SCDHHS shall begin to review beneficiary history for related claims as appropriate (both claims already received and processed and those received subsequent to the notification of the surgical error). Also, the PI Division or its designee will audit all claims for the recipient to determine if they relate to or have the potential to be related to the original Never Event claim. When, PI or its designee identifies such claims, it will take appropriate action to deny such claims and to recover any overpayments on claims already processed.

Every 30 days for an 18-month period from the date of the surgical error, PI or its designee will continue to review recipient history for related claims and take appropriate action as necessary. Related services do not include performance of the correct procedure.

General Provisions

Medicaid will not pay any claims for “provider-preventable conditions” for any member who is Medicare/Medicaid eligible.

No reduction in payment will be imposed on a provider for a provider preventable condition, when the condition defined as a PPC for the particular member existed prior to the initiation of the treatment for that member by that provider.

Reductions in provider payments may be limited to the extent that the following apply:

- The identified PPC would otherwise result in an increase in payment.
- The SCDHHS can reasonably isolate for non-payment the portion of the payment directly related to treatment for and related to the PPC.

To review the complete Health Acquired Conditions policy, please visit:

<http://www.cms.gov/HospitalAcqCond>.

Exploratory Procedures

If a procedure is carried out through the laparotomy incision, the physician may choose to bill for either the laparotomy or the actual procedure performed during the surgery; most likely, it will be the code that reimburses the higher rate. In any case, South Carolina Medicaid will sponsor payment for either the procedure or the laparotomy, not both.

Under the same principle, when a surgical procedure is performed through an endoscope, the diagnostic endoscopy is inclusive in the reimbursement. The physician may be reimbursed for either the endoscopic procedure or the diagnostic endoscopy, not both.

When endoscopy procedures are performed in the office, small supplies and materials provided by the physician over and above those usually included with the office visit may be billed. A minor surgical tray may also be billed.

Multiple Surgery Guidelines

Multiple surgeries include separate procedures performed through a single incision, or separate procedures performed through second and subsequent incisions or approaches. All surgical procedures for the same DOS should be filed on one claim form when possible.

Payment Guidelines

When multiple surgeries are performed at the same operative session, the procedure that reimburses the highest established rate will be considered the primary procedure and will be reimbursed at 100% of the established rate. All second and subsequent surgeries performed at the same operative setting will be reimbursed at 50% of the established rate. Procedure codes that are exempt from multiple procedure reduction as outlined by the AMA in the CPT Standard Edition are reimbursed at 100%.

A vaginal delivery and tubal ligation performed on the same DOS will not be affected by this policy. Both procedures are reimbursed at 100%, even when performed on the same day. Use the 79 modifier on the tubal ligation to ensure correct reimbursement.

Modifiers

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance must be identified by the addition of the appropriate modifier code, which must be reported by adding a two-digit number (modifier) placed after the procedure number. Modifiers commonly used in surgery are listed in the surgery section of the CPT and on the provider portal. Only the first modifier indicated will be used to process the claim — Medicaid will key only the first modifier indicated for each procedure.

Billing

Claims for surgery must be filed using the CPT code that most closely describes the surgical procedure that was performed. When this is not applicable, an unlisted procedure code may be used and the appropriate documentation should be attached to the claim form for adequate reimbursement.

Claims for more than one surgical procedure performed at the same time by the same physician must be billed as follows:

- On a single claim form, unless more than six procedures are performed.

Note: If more than one surgical procedure is billed for the same DOS on different claims, the second claim that processes may reject. To avoid this delay, file all surgical procedures for the same DOS on one claim form.

- Only for subsequent procedures which add significantly to the major surgery or are not incidental to the major surgery.
- Using the appropriate modifier (Medicaid will key the first modifier indicated for each procedure only).
- With charges listed separately for each procedure.

When identical procedures (not bilateral) are billed for the same day, the first should be billed without a modifier, and the second with modifier 51. If the same procedure is billed a third time, the claim must be filed hardcopy with supporting documentation.

Modifier 62 should be used to indicate that the skills of two surgeons were required. Modifier 66 should be used to indicate circumstances requiring a surgical team. These modifiers will ensure proper reimbursement for each provider involved.

Modifier 52 should be used to describe reduced services. Modifier 53 is used to describe a discontinued procedure. Both modifiers will be reimbursed at 50% when billed with a surgical procedure.

Separate Procedures Performed on the Same DOS

When two separate surgical procedures are performed on the same DOS at different operative sessions, both procedures will be allowed 100% of the established rate.

To report, submit the second procedure with the 78 or 79 modifier. This will ensure that both procedures will be paid at 100%. If not reported in this manner, the lower priced of the two procedures will be reimbursed at 50%. All surgical procedures performed on the same DOS should be filed on the same claim form whenever possible.

Procedure Codes That Multiply

Occasionally the CPT defines certain procedure codes as "each", indicating the possibility of multiple procedures. When filing these types of codes, list the code one time for the DOS and bill the appropriate number of units in the "units" column of the claim form and the total charge for the number of units billed. If there is only one surgical procedure for the DOS and multiple units are billed, payment for codes that multiply will be 100% of the established rate for the first unit and 50% for each additional unit(s) filed. If a surgical procedure with a higher established rate is performed on the same DOS, the higher established rate will be allowed and the code(s) to multiply will pay 50% of the established rate per unit filed.

Automatic Adjustments to Paid Surgical Procedures

All surgical procedure codes for the same patient and same DOS should be filed on the same claim form. This ensures that the correct procedure will reimburse at 100% of the established rate. At times, however, surgical codes are filed on separate claim forms, causing incorrect payments and the need for adjustments.

Automatic adjustments work in the following manner: When a claim for a surgical procedure code is submitted, the system will review the paid claims history for that patient, DOS and provider. If there is no previously paid surgical code(s) on file for that DOS, the surgery will pay at 100% of the established rate. If, however, there is a previously paid surgery on file for that patient, DOS, and provider, the system will compare the previously paid surgery and the newly submitted surgical code. It will then determine which of the codes should correctly reimburse the provider at 100%. If the newly submitted surgical code should pay at 100%, the system will make an automatic adjustment against the previously paid surgical code by subtracting 50% of the previously paid procedure from the amount to be reimbursed for the newly submitted surgical code. Therefore, the newly submitted surgical code will be allowed at 100% although the payment may not reflect the full amount due because of the recoupment of 50% of the previously paid procedure.

When the system reviews paid claims history for a patient, DOS and provider, and finds that the previous surgical claim paid correctly at 100% and the second surgical claim should pay at 50% of the established rate, there will be no adjustment as the claim will pay correctly.

Bilateral Surgery

To report a bilateral procedure, bill the first procedure with no modifier, and the second procedure with a 50 modifier. Report on two lines instead of one. A bilateral procedure billed with only one line will result in underpayment. Codes with bilateral descriptions may not be billed with a 50 modifier.

Claims filed for an assistant surgeon performing a bilateral procedure should be filed hardcopy with documentation using the 80, 81 or 82 modifier on both lines of the procedure code that is bilaterally performed.

Bilateral procedures will be reimbursed at 100% for the first procedure, and 50% for the second procedure (same as multiple procedures). If the bilateral procedure is billed in conjunction with another procedure that is normally reimbursed at a higher rate than the bilateral procedure, then each of the bilateral procedures will be reimbursed at 50%.

Billing Procedures

Surgical endoscopic procedures **always include** the diagnostic endoscopy. Therefore, the diagnostic endoscopy code is not allowed in addition to the surgical endoscopy for the same anatomical site.

Under the same principle, when a surgical procedure is performed through an endoscope, the diagnostic endoscopy is inclusive in the reimbursement. The physician may be reimbursed for either the endoscopic procedure, or the diagnostic endoscopy, not both.

Endoscopic procedures do not require a 26 modifier when performed in the inpatient or OP hospital setting.

When two endoscopic procedures are performed on the same DOS, the first procedure should be reported without a modifier, and the second procedure should be reported with modifier 51.

Ambulatory Surgical Services

To bill for the professional service, the surgeon should submit claims following the usual surgical guidelines, using place of service "24".

Surgical Package

The surgical package includes post-operative care for 30 days following surgery. Post-operative services rendered and billed during this 30-day period will be rejected for an 854 edit code. Normal post-operative care is considered part of the surgical package and includes office examinations and all hospital follow-up visits, including discharge management. Hospital and office E&M visits are allowed up to and including the day of surgery.

ER services and critical care are not considered part of the surgical package. They may be billed in addition to the surgery performed. For guidelines on delivery admissions, please refer to Perinatal Care under Obstetrics and Gynecology within this section of the manual.

Surgical procedures that are billed within 30 days prior to a paid office or hospital visit will suspend for review. If applicable, the office or hospital visit(s) will be recouped and the surgery claim will process for payment. The surgical procedure may be rejected with edit 855. In that case, providers should submit a new claim and indicate that the surgery should be paid and the visits should be recouped.

Ambulatory Surgical Services

Complications or services rendered for a diagnostic reason unrelated to the surgery may be billed with a separate examination code if the primary diagnosis reflects a different reason for the service.

To report post-operative visits unrelated to surgery, submit the visit code(s) with modifier 24 or 25. The medical record must substantiate that a visit(s) was justified outside of the surgical package limitation.

Follow-up care in the office and/or hospital may be billed if the surgery is an exception to the surgical package.

Assistant Surgeon

When billing for the assistant surgeon's fee, the modifier 80, 81, or 82 must accompany all procedure codes filed. Assistant surgeons must be physicians. Medicaid will not reimburse non-physician surgery assistants.

If, due to unforeseen circumstances, the surgery did require an assistant, and an assistant surgeon is not allowed for the surgical procedure, Medicaid will review the claim for reimbursement. Providers may submit a new claim with documentation for medical review. The medical record must justify the special need for an assistant surgeon.

An assistant surgeon will be reimbursed at 20% of the total allowable fee per procedure.

An assistant surgeon must use the same CPT procedure codes as the primary operating surgeon. The assistant surgeon modifier is the only modifier required for each procedure billed. Medicaid will only key the first modifier indicated.

The claim for the assistant surgeon must be submitted with a different individual provider number (rendering physician) from the primary surgeon. The assistant surgeon must be enrolled with South Carolina Medicaid in order to receive reimbursement.

Claims filed for an assistant surgeon performing a bilateral procedure should be filed using the 80, 81 or 82 modifiers.

SURGICAL GUIDELINES FOR SPECIFIC SYSTEMS

Integumentary System

Lesion Removal

Supporting documentation is required for a claim submitted for a lesion and a dermal anomaly removal or revision with diagnosis codes L91.0 and L90.5. Medicaid will not cover treatment that is considered to be experimental, investigational (i.e., chemical peels, cryosurgery, dermabrasion, punch grafts, bleomycin, interferon and verapamil injections), or done for cosmetic or emotional purposes.

Keloid/Scar Conditions

Claims for these treatments must be accompanied by documentation that supports the criteria as outlined above. Medicaid will not provide coverage for excision and/or treatment of non-malignant dermal lesions, dermal anomalies and Keloid/scar conditions under the following circumstances:

- The treatment is performed for cosmetic or emotional purposes.
- The therapy is experimental or investigational.

Examples include chemical peels, cryosurgery, dermabrasion and punch grafts.

Skin Grafts

Providers should follow CPT guidelines when billing for skin grafts. Procedures are identified by size and location of the defect (beneficiary area) and the type of graft. Skin graft codes that pertain to subsequent (each additional square centimeter) areas should be billed in units.

ANESTHESIA SERVICES

Time Reporting

South Carolina Medicaid only accepts actual time when billing for anesthesia services. Report time in minutes, in the “units” field (Item 24G) of the CMS-1500 claim form.

Example:

Anesthesia Start Time — 1:15 pm

Anesthesia Stop Time – 2:45 pm

Total Anesthesia Time Billed in Minutes — 90 minutes

Modifiers of Anesthesia Services

Unless anesthesia services are provided and billed as supervision, the administration of anesthesia must be personally provided by the physician, who remains in constant attendance of the patient. Anesthesiologists must indicate this by using the AA modifier in conjunction with the appropriate anesthesia CPT code.

Anesthesiologists billing as a member of the anesthesia team, for supervision of anesthesia services rendered by a CRNA/AA, resident or intern, must use the modifier listed below which best reflects the situation:

- QY — Medical direction of one CRNA by an anesthesiologist.
- QK — Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.
- AD — Medical direction of more than four concurrent procedures involving qualified individuals.

Anesthesia procedures that involve both a supervising anesthesiologist and a CRNA/AA will have reimbursement divided so that the anesthesiologist receives 60% and the CRNA/AA will receive 50% of the established reimbursement rate for the procedure. The anesthesiologist will bill his or her services using the QY modifier and the CRNA will bill using QX.

If the complexity of a surgery or complications that develop during surgery require both the CRNA and the anesthesiologist to be involved completely and fully in a single anesthesia case, both providers may bill for their services. The complexity of service or complications must be clearly documented in the patient's records and submitted with the claim. The anesthesiologist must bill using the AA modifier, anesthesia services performed personally by anesthesiologist. The CRNA must bill using the QZ modifier. These claims must be filed hardcopy with documentation supporting the need for both professionals.

Routine scheduling of a CRNA/AA, resident or intern to assist an anesthesiologist in the care of a single patient does not justify medical necessity.

CRNAs billing for services rendered under the medical direction of a surgeon must indicate this by using the QZ modifier (CRNA service: without medical direction by a physician) in conjunction with the appropriate CPT anesthesia code. CRNAs not working under the medical direction of a surgeon will be reimbursed at 87% of the anesthesiologist reimbursement rate.

CRNA/AAs billing for services rendered as a member of the anesthesia team, under the supervision of an anesthesiologist, must indicate this by using the QX modifier in conjunction with the appropriate CPT anesthesia code.

The monitored anesthesia care modifiers QS, G8 and G9 do not describe medical direction involved in the anesthesia procedure. The monitored anesthesia care modifiers describe the type of anesthesia care. It is important to use a modifier that describes the medical direction involved as the first modifier when using more than one; Medicaid only accepts one modifier.

Procedures

Intubation

Payment is allowed for intubation (31500) performed in the intensive care unit or ER by an anesthesiologist or CRNA. Intubation is considered a regular part of anesthesia services and may not be a fragmented charge when performed in conjunction with anesthesia services.

Catheter Placement

Anesthesiologists are reimbursed for placement of central venous, subclavian, arterial or Swan-Ganz catheters in addition to anesthesia services. CRNA/AAs will not be reimbursed for these codes. Refer to the provider portal for a list of codes.

Spine and Spinal Cord Puncture for Injection

Medicaid reimburses personally performing anesthesiologists and CRNAs for the following spine and spinal cord puncture codes. Either the anesthesiologist or CRNA may bill for the codes listed below without a modifier, but not both.

For placement of the continuous epidural catheter, an anesthesiologist or CRNA, personally performing or supervised, bills the appropriate code with the appropriate modifier. Please refer to the provider portal for a list of appropriate codes.

Laboring Epidural

The continuous epidural codes for the vaginal delivery and a vaginal delivery becoming a C-section reimburses a flat rate regardless of the time involved. The anesthesiologist and CRNA must bill with the appropriate modifier indicating personally performed or as part of an anesthesia team.

When a vaginal delivery becomes a C-section and the catheter remains in place for the C-section, you must bill for the vaginal delivery and then use the add-on code. This is an add-on code and therefore must be billed in conjunction with the procedure code.

If the C-section is performed under general anesthesia you may bill the time for the C-section only, in addition to the labor and delivery epidural.

For a scheduled C-section, an anesthesiologist or CRNA bills with payment based on time.

When a tubal is performed at a later surgical session and the same catheter remains in place and is re-dosed, it is not appropriate to bill general anesthesia based on time.

Anesthesia Consultations

Consultative services rendered on behalf of any direct or indirect patient care are included in the basic value of the anesthesia payment and may not be charged separately. However, if an anesthesiologist is requested to consult with another physician or hospital anesthesiologist, or examines a patient to determine the appropriate anesthetic agent and does not furnish direct anesthesia

services or assume direct supervision of the anesthesia service, then the anesthesiologist may bill a separate consultation code based on the appropriate level of service.

The anesthesiologist may bill a consultative code if the surgery is cancelled. An anesthesiologist may not charge a consultative service in addition to any anesthesia service (either for supervision or direct care).

Fragmented Charges

Services considered an integral part of anesthesia services, such as blood gases, venipuncture, oxygen capacity, blood transfusions, administration of medications, intubation in the operating room, etc., are non-compensable when billed separately.

PAIN MANAGEMENT SERVICES

Post-Operative Pain Management

Physicians billing for post-operative pain management should bill the single or continuous procedure code when the insertion of the epidural catheter is for purposes other than surgical anesthesia. These codes include an allowance for insertion of the needle or catheter into the epidural space, and an allowance for injecting the drug or medication through the portal. If a continuous epidural is used for surgical anesthesia and remains in for post-operative pain, an additional insertion cannot be billed for management of the post-operative pain. These procedures should be billed without a modifier for the initial insertion.

Daily management of the epidural analgesia should be billed on days subsequent to the day of insertion of the epidural catheter. Up to five days of post-operative pain management may be allowed without additional documentation to justify the extended service. Unless a separately identifiable service has been rendered on the same day, do not bill any other service, including an E&M code.

Modifier QZ or AA (anesthesia services performed personally by anesthesiologist) must be used with the appropriate service. Please refer to Anesthesia Services within this section of the manual for a description of these modifiers.

Nerve Blocks

Physicians are reimbursed for injection of anesthetic agents for nerve blocks. Anesthesiologists bill for these services without a modifier. Use separate procedure codes for trigger point injections that may also be billed by the anesthesiologist with no modifier.

Injecting any substance through the needles, including small amounts of contrast to confirm the position of the needle, is considered an integral part of the procedure and is not reimbursed separately.

When destruction of the facet joint nerve is performed following the block, only the codes for the nerve destruction should be billed, since their allowance includes the nerve block procedure.

PATHOLOGY AND LABORATORY SERVICES

In accordance with Title XIX of the Social Security Act, Medicaid reimbursement for laboratory fees cannot be higher than the Medicare fee schedule established for laboratory services. Fee schedules are located on the SCDHHS website at: <http://www.scdhhs.gov>.

It is further mandated that only the actual provider of the service or the provider performing the test may charge and receive Medicaid reimbursement. Providers cannot bill Medicaid patients when Medicaid would have paid for the lab service if the appropriate billing procedures and referral procedures had been followed.

Services or supplies administered by the hospital or hospital employees are considered a part of the overall hospital service and are reimbursable only under the hospital allowable costs. A physician who is either salaried or contracted by the hospital, and who performs services under contract or employment, may not bill for those services separately under his or her individual Medicaid provider number. The contracting hospital may file for these services under the professional fees allowable for the hospital under their hospital-based physician's Medicaid number.

Professional component services constitute the professional interpretation and report and must be charged using the 26 modifier. Claims for professional pathology services indicating a hospital as the place of service will be rejected if submitted without the 26 modifier. Only anatomical, surgical, and the clinical pathology procedures listed earlier in this section are reimbursable with a 26 modifier.

TC services are those services usually performed by a hospital in the administration of a hospital lab. These services include payment for a lab technician, equipment and supplies. Only a hospital may bill for separate technical lab services.

Total lab procedures are a combination of both the professional and TCs. Usually an independent laboratory or a private practicing physician performing his or her own lab services is the only provider eligible for a total lab reimbursement rate. Pathologists and laboratories may bill for beneficiaries that are in the Family Planning Eligibility category only, but a valid family planning diagnosis code must be present on the claim, along with the FP modifier.

Automated Chemistry Tests and Panels

Providers billing for automated multi-channel chemistry tests may bill these tests individually as described in the CPT coding manual. The system will bundle specific tests and reimburse one rate based on the number of tests performed. Claims with less than three of these tests will pay each individual test based on the fee schedule. The list above identifies those codes, when billing three or more, that are bundled to pay one rate based on the number of tests. A provider may also bill for

individual tests that are assigned to a panel. If the individual tests are included on the list, these tests will also bundle when three or more are filed on the same claim form and pay one rate based on the number of tests.

Fee schedules are located on the SCDHHS website at: <http://www.scdhhs.gov>.

Blood

Medicaid requires that the securing supplier of blood products bill those products or packed cells. If a hospital laboratory secures the packed cells and washes, then the hospital must charge for the blood. A physician, clinic or other non-securing provider may not bill for the blood. In addition to the products, the securing provider may only bill for additional type and cross matching, if appropriate, and the transfusion.

Professional Pathology Services

A pathologist may charge for a clinical lab interpretation if requested by the attending physician and reported as a contribution to direct patient care. This diagnostic procedure must be charged for limited and comprehensive services, respectively.

Interpretation of clinical lab tests will not be reimbursed. Only charges for consultations on clinical lab tests may be recognized. A professional component modifier is not required (26). General consultation procedures are not compensable for professional clinical lab services.

Independent Laboratories

Whenever an independent laboratory charges Medicaid with an unlisted procedure, support documentation is required. Since SCDHHS and most independent laboratories recognize the mutual benefits of automated claims processing, steps should be taken to insure timely and efficient claims submission.

When a laboratory initiates a new lab test(s) or a new combination, notification should be sent to the Pathology program manager. This preliminary process will quicken the assignment of a code and approval for Medicaid payment.

Independent laboratories must submit charges on a CMS-1500 claim form with the appropriate CPT or supplemental code. The place of service must be an "81" and the DOS when the test was performed must be indicated.

Independent labs may bill for beneficiaries who are in the Family Planning Eligibility category only. A valid family planning diagnosis and modifier must be present on the claim.

Clinical Laboratory Improvement Amendments (CLIA)**Claims Editing**

Claims will be denied for lab services delivered by any lab site meeting one or more of the following descriptions:

- A lab that does not have CLIA certification.
- A lab that submits claims for services not covered by CLIA certificate.
- A lab that submits claims for services rendered outside the effective dates of the CLIA certificate.

Individual physicians who are members of a group should bill under the group number. The CLIA editing is based on the provider number in field 33 of the CMS-1500. For more detailed information, please refer to the Provider Administrative and Billing Manual.

Lab Procedures

The following sections indicate the lab procedures allowed for each type of certification. Current CLIA information can be found on the Internet at: <http://www.cms.hhs.gov/clia/>.

Labs issued a Certificate of Registration, Certificate of Accreditation or Partial Accreditation, or Certificate of Compliance are allowed to perform and bill for the following procedures:

- All pathology and lab procedures
- Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling
- Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); multiple areas
- Red cell volume determination (separate procedure); single sampling
- Red cell volume determination (separate procedure); multiple samplings
- Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)
- Red cell survival study
- Platelet survival study
- Vitamin B-12 absorption study (e.g., Schilling test); without intrinsic factor

- Vitamin B-12 absorption study (e.g., Schilling test); with intrinsic factor
- Vitamin B-12 absorption studies combined, with and without intrinsic factor
- Culture and sensitivity urine only

Labs issue a Certificate of Waiver limited to performing only the following procedures:

PROCEDURE		
Lipid panel	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein specific gravity, urobilinogen, any number of constituents; non-automated, without microscopy	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein specific gravity, urobilinogen, any number of constituents; automated, without microscopy
Bacteriuria screen, exp culture/dips	Urine pregnancy test, by visual color comparison methods	Albumin, urine, microalbumin, semiquantitative (e.g., reagent strip assay)
Amines, vaginal fluid, qualitative	Blood, occult; feces, one to three simultaneous determinations	Cholesterol, serum, total
Collagen cross links; any links	Creatinine; other source	Glucose; quantitative
Glucose; post glucose dose (includes glucose)	Glucose; tolerance test, three specimens (includes glucose)	Glucose; tolerance test, each additional beyond three specimens
Glucose, blood, by glucose monitoring device(s) cleared by the FDA specifically for home use	Glutathione Reductase RBC	Glycated protein
Gonadotropin; follicle stimulating hormone	Gonadotropin; luteinizing hormone	Hemoglobin; by copper sulfate method, non-automated
Hemoglobin; glycated	Immunoassay analyte not antibody, single step method	Lactate (Acetic acid)
Lipoprotein, direct measurement; high-density cholesterol (HDL cholesterol)	pH, body fluid, except blood	Transferase; alanine amino
Triglycerides	Gonadotropin chorionic qualitative	Unlisted chemistry procedure
Blood count; spun microhematocrit	Blood count; other than spun hematocrit	Blood count; hemoglobin
Prothrombin time	Sedimentation rate, erythrocyte; non-automated	Immunoassay for tumor antigen, qualitative or semiquantitative; (EG, bladder tumor antigen)

PROCEDURE		
Heterophile antibodies; screening	Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (e.g., reagent strip)	Antibody; borrelia burgdorferi (Lyme Disease)
Culture, bacterial; aerobic isolate, additional methods for definitive identification, each isolate	Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, not otherwise specified, each organism	Infectious agent antigen detection by immunoassay with direct optical observation; influenza
Streptococcus, screen, direct	Anaerobic isolate, additional methods required for definitive identification, each isolate	Aerobic isolate, additional methods required for definitive identification, each isolate

Labs issued PPMP Certificates are allowed to perform the above listed procedures for Certificate of Waiver **and** the following procedures:

- Fecal Leukocyte examination
- Semen analysis
- Wet mount, including preparations of vaginal, cervical, or skin specimens
- All potassium hydroxide preparations
- Pinworm examinations
- Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
- Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrate, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
- Urinalysis; microscopic only
- Urinalysis; two or three glass test
- Nasal smear for eosinophil

RADIOLOGY AND NUCLEAR MEDICINE

Positron Emission Tomography (PET) Scans

Providers billing for radiopharmaceutical diagnostic imaging agents utilizing a CMS-1500 claim form should select the appropriate HCPCS code. When billing for an unlisted radiopharmaceutical agent the provider must include a copy of the invoice with the CMS-1500 claim form for review.

Clinical Treatment Management

If at the final billing of the treatment course, there are three or four fractions beyond a multiple of five, those three or four fractions are considered a week. If there are only one or two fractions beyond a multiple of five, reimbursement for the sessions will be considered as having been covered through prior payment.

When the patient receives a mixture of simple, intermediate, and/or complex services, bill the code that represents the majority of the fractions furnished during the five fraction week.

Independent Imaging Centers and Mobile Imaging Units

Mobile units may bill the following codes for set-up and transportation in addition to the x-ray or EKG when the patient would require special transportation. These codes should be billed without a modifier:

- Set up of portable x-ray equipment in a nursing facility, per radiological procedure (other than re-takes of the same procedure). Medicaid will not reimburse for re-takes.
- Round trip transportation of portable x-ray equipment and personnel to nursing home, per trip to facility or location; one patient seen.
- Round trip transportation of portable x-ray equipment and personnel to nursing home, per trip to facility or location; more than one patient seen, per patient.
- Round trip transportation of portable EKG to facility or location; per patient.

Charges should be submitted on a CMS-1500 claim form with the following restrictions:

- All CPT procedure codes should be submitted with a TC modifier.
- Separate charges for injection of contrast mediums, radiopharmaceuticals or catheterizations are not covered.

Modifiers and Components

Radiology services are divided into the following defined components:

- TC — Includes equipment, supplies and technician time and effort. Provider must bill using the TC modifier.
- Professional Component — Includes the physician's supervision, interpretation, and report, and when appropriate, the physician's administration of an injection or catheterization. Payment will be made to the physician or radiologist who performed the interpretation and written report at the time of the diagnosis and treatment. Provider must bill using the 26 modifier.
- Complete Procedure — Is the combination of both the technical and professional services. Provider must bill 00 modifier.
- 76 modifier — The use of the 76 modifier can only be used on medically necessary repeat radiology procedures performed on the same DOS and must include both the technical and professional components.

Providers must bill using the appropriate modifiers which are determined by the parameters of services rendered. Therefore, if a rendering provider is only submitting the TC of the procedure, use the TC modifier along with the procedure code performed. If the claim is submitted utilizing the UB format, the modifier TC will be assumed. No further payment will be made to any additional provider for the TC for this procedure.

If the rendering provider is submitting the professional component/interpretation of the radiological procedure, use the 26 modifier along with the procedure code performed. No further payment will be made to any additional providers for the professional component of the procedure.

FEDERALLY QUALIFIED HEALTH CENTER SERVICES

FQHC Adult Nutritional Counseling Program

All ICD-CM codes must be billed as secondary diagnosis codes. All providers and dietitians are required to bill with a primary diagnosis code. The following requirements must be met:

- Providers and dietitians must bill utilizing the Adult Nutritional Counseling ICD-10 and HCPCS codes and modifier combinations found on the provider portal.
- Providers may bill subsequent visits with one-on-one counseling or group counseling.
- Services will be reimbursed for place of service 22 (clinics).
- Dietitians must bill utilizing the above referenced codes.
- Nutritional counseling units are billed based on a 30-minute session and are limited to one unit per day.

All providers and dietitians are responsible for clearly documenting the patient's chart with all information referenced in this policy. All services rendered by both providers and dietitians are subject to review by the Division of Program Integrity. Services not meeting the requirements reflected in this policy may be subject to recoupment by SCDHHS.

FQHC Children's Nutritional Counseling Program

FQHCs must meet the following billing requirements to be reimbursed for obesity services:

- Providers and dietitians must bill utilizing the appropriate HCPCS code.
- Providers and dietitians may bill only one T1015 for the combination of their services. Please refer to the provider portal for additional billing code information.
- Providers and dietitians are allowed a maximum of six encounters in a year for the treatment of obesity.
- Services will be reimbursed for places of service 11 (office) and 22 (clinic).

Providers and dietitians are responsible for clearly documenting the child's chart with all information referenced in this policy. All services rendered by both providers and dietitians are subject to review by the Division of Program Integrity. Services not meeting the requirements reflected in this policy may be subject to recoupment by SCDHHS.

Encounter and Ancillary Service Coding

All encounter codes and ancillary services listed in this section must be billed under the FQHC provider number. Only one encounter code may be billed per day, with the exception of the Psychiatry and Counseling Encounter, which can be billed in addition to another encounter on the same day. The most appropriate encounter code must be billed based on the service(s) provided. All supplies, lab work, injections, surgical procedures (unless noted in the Special Clinic Services section of this manual), etc., are included in the encounter code reimbursement. The only fragmented services billable on a FFS basis are listed under Special Clinic Services.

Medical Encounter

All medical encounters must be billed using the appropriate encounter code unless otherwise specified. A medical "visit" (encounter) is defined as a face-to-face encounter between a patient and the physician, PA, NP, chiropractor or CNM during which an FQHC core service is provided. FQHC providers will be reimbursed their contracted encounter rate, and are allowed only one medical encounter per day, even if the patient sees more than one professional at the visit or on that day. The use of this code counts toward the ambulatory visit limit for beneficiaries age 21 or older.

Maternal Encounter

All maternal care encounters must be billed with the appropriate encounter code with a TH modifier. FQHC providers will be reimbursed their contracted rate for all maternal services rendered. The use of this procedure code and a TH modifier will not affect the beneficiary's number of allowable ambulatory visits. IUDs, the TC of ultrasounds, and NSTs may be billed separately. Please refer to Family Planning and Special Clinic Services coding guidelines below.

Psychiatry and Counseling Encounter

For Behavioral Health policies and procedures please refer to the FQHC Behavioral Health Services Provider Manual located on our website at: <http://www.scdhhs.gov/>.

Cancer Treatment and HIV/AIDS Encounter

SCDHHS allows FQHCs to bill for HIV/AIDS and cancer-related services using the appropriate encounter code, with the P4 modifier.

The use of this code and the P4 modifier will not count toward the beneficiary's ambulatory visit limit if the beneficiary is age 21 or older. Charges for such services will be reimbursed at the contract rate.

Special Clinic Services

NSTs, EKGs and x-rays performed in the center must be billed using the appropriate CPT code with a TC modifier indicating the TC only. The professional component is reimbursed through the encounter code that may be billed (if appropriate). If the patient is referred to a radiologist, cardiologist, etc., for interpretation, the specialist's services are reimbursed FFS following Medicaid policy for their specialty.

FQHC Crossovers

Crossover claims must be filed initially to the assigned FQHC Medicare intermediary. Upon payment from Medicare, the claim must be filed to Medicaid on the CMS-1500 claim form showing the payment received from Medicare.

CLINIC-BASED PHYSICIAN POLICY

All hospital services must be billed under the clinic-based physician (CBP) number.

Hospital Services

The CBP program covers the billing for physician, CNM, and NP services rendered by FQHC providers at a hospital.

All services provided to hospital patients (including ER services) by a FQHC provider must be billed under the CBP program. These services must be billed using the Physician's CPT codes and will not be cost-settled.

Providers must bill for these services using the CBP provider number (Section 33) and rendering physician, CNM or NP's Medicaid provider number (Section 24K) on the CMS-1500 claim form.

RURAL HEALTH CLINIC

SCDHHS administers a cost-based, retrospective, reimbursement payment methodology.

Reimbursement for medically necessary services shall be made at 100% of the all-inclusive rate per encounter as obtained from the Medicare intermediary. Actual cost information, to include Medicare annual RHC rate caps, shall be obtained from Medicare Intermediary at the end of the RHC's fiscal reporting period to enable SCDHHS to determine the reimbursement due for the period.

Provider-based RHCs with less than 50 beds will receive reimbursement at 100% of Medicare reasonable costs not subject to the RHC rate cap. For provider-based RHCs, actual cost and utilization information based on the RHC's fiscal year shall be obtained from the HCFA-2552-96 actual cost report.

Services may be billed electronically or on paper, using the CMS-1500 claim form. Medicaid encourages electronic billing. When claims are submitted electronically, mistakes can be corrected immediately, and claims are processed without delays. The following billing procedures apply to the RHC program.

Laboratory Services

All laboratory services (including the six laboratory tests required for RHC certification) must be billed to Medicaid under your FFS Medicaid provider identification number. Laboratory services cannot be billed using your RHC provider number.

NSTs, EKG's and x-rays performed in the center must be billed using the appropriate CPT code with a TC modifier indicating the TC only. The professional component is reimbursed through the encounter code that may be billed (if appropriate). If referred to a radiologist, cardiologist, etc., for interpretation, their services are reimbursed FFS following Medicaid policy for their specialty service.

Hospital care services provided by medical professionals of the clinic are compensable under the special clinic service guidelines.

RHC Adult Nutritional Counseling Program

All V codes must be billed as secondary diagnosis codes. All providers and dietitians are required to bill with a primary diagnosis code. The following requirements must be met:

- Providers and dietitians must bill utilizing the HCPCS code and modifier combinations as described above.
- Providers may only bill the initial obesity visit on the same day as an E&M service or physical exam.
- Providers must not bill for subsequent obesity exams on the same day as an E&M service.

- Providers may only bill for the appropriate nutritional counseling HCPCS code one unit per day per patient.
- Providers may bill subsequent visits with one-on-one counseling or group counseling.
- Services will be reimbursed for places of service 11 (office) and 22 (clinic).
- Dietitians must bill utilizing the above referenced codes.

Nutritional counseling units are billed based on a 30-minute session and are limited to one unit per day.

All providers and dietitians are responsible for clearly documenting the patient's chart with all information referenced in this policy. All services rendered by both providers and dietitians are subject to review by the Division of Program Integrity. Services not meeting the requirements reflected in this policy may be subject to recoupment by SCDHHS.

RHC Children's Nutritional Counseling Program

RHCs must meet the following billing requirements to be reimbursed for obesity services:

Providers and dietitians must bill utilizing the Children's Nutritional Counseling ICD-10 and HCPCS codes and modifier combinations found on the provider portal.

- Providers must not bill for initial or subsequent obesity exams on the same day as an E&M service.
- Providers may bill subsequent visits with one-on-one counseling or group counseling by appending the HB modifier to the E&M service.
- Services will be reimbursed for places of service 11 (office) and 22 (clinic).
- All groups are limited to five patients per setting.
- Nutritional counseling units billed are based on a 15-minute session and are limited to two units per day, with a maximum of 12 in a year.

Providers and dietitians are responsible for clearly documenting the child's chart with all information referenced in this policy. All services rendered by both providers and dietitians are subject to review by the Division of Program Integrity. Services not meeting the requirements reflected in this policy may be subject to recoupment by SCDHHS.

Providers and dietitians are responsible for clearly documenting the child's chart with all information referenced in this policy. All services rendered by both providers and dietitians are subject to review by the Division of Program Integrity. Services not meeting the requirements reflected in this policy may be subject to recoupment by SCDHHS.

Encounter and Ancillary Service Coding

The following coding guidelines must be followed for RHC services. All encounter codes and ancillary services listed in this section must be billed under the RHC provider number. Only one encounter code may be billed per day, with the exception of the psychiatry and counseling encounter, which can be billed in addition to another encounter on the same day.

The most appropriate encounter code must be billed based on the service(s) provided. All supplies, injections, surgical procedures, etc., are included in the encounter code reimbursement. The only fragmented services billable on a FFS basis are listed under Special Clinic Services below.

Medical Encounter

All medical encounters must be billed using the appropriate code unless otherwise specified. A medical "visit" (encounter) is defined as a face-to-face encounter between a patient and the physician, PA, NP, chiropractor or CNM during which an RHC core service is provided. RHC providers will be reimbursed their contracted encounter rate and are allowed only one medical encounter per day, even if the patient sees more than one professional at the visit or on that day. The use of this code counts toward the ambulatory visit limit for beneficiaries age 21 and older. are allowed 12 ACVs per year, commencing on July 1st of each year. Beneficiaries under age 21 are exempt from this limitation.

Maternal Encounter

All maternal encounters must be billed using the appropriate code with a TH modifier. RHC providers will be reimbursed their contracted rate for all maternal services rendered. The use of this procedure code and a TH modifier will not affect a beneficiary's number of allowable ambulatory visits. The following may be billed separately, please refer to the Family Planning and Special Clinic Services sections below for coding guidelines.

Psychiatry and Counseling Encounter

For Behavioral Health policies and procedures please refer to the RHC Behavioral Health Services Provider Manual located on our website at: <http://www.scdhhs.gov/>.

Cancer Treatment and HIV/AIDS Encounter

SCDHHS allows the RHC to bill for HIV/AIDS cancer-related services, with the P4 modifier. The use of this code and the P4 Modifier will not count toward the ambulatory visit limit for beneficiaries aged 21 or older. Charges for such services will be reimbursed at the contract rate.

Family Planning

For more information regarding how to bill Family Planning services, see the Evaluation and Management Services portion of this section.

Special Clinic Services

For more information regarding how to bill for Special Clinic services, see FQHC Crossovers within this section of the manual.

RHC Medicare/Medicaid Dual Eligibility Claims

Claims for RHC services must be filed initially to the Medicare intermediary. Upon payment from Medicare, the claim must be filed to Medicaid on the CMS-1500 claim form showing the payment received from Medicare. Medicaid will pay the difference up to the provider's RHC rate.

WRAP-AROUND PAYMENT METHODOLOGY

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection ACT of 2000 (BIPA) require the determination of supplemental payments for FQHCs and RHCs contracting with Medicaid MCOs. These supplemental payments are calculated and paid to ensure that these providers receive reimbursement for their services to Medicaid MCO beneficiaries at least equal to the payment that would have been received under the traditional FFS methodology. These determinations, generally referred to as wrap-around payments, are mandated by BIPA 2000 to be completed at least every four months. SCDHHS performs these determinations quarterly and prepares a final reconciliation at the provider's year-end. Submission of quarterly and annual MCO encounter data and payment information that is required for these wrap-around payment determinations is the responsibility of each MCO contracting with FQHCs and RHCs. The quarterly and annual reconciliation processes are incorporated into the agency's State Plan for Medical Assistance, Section 4.19-B.

Questions relating to the RHC reimbursement methodology or wrap-around payments should be directed to the SCDHHS Division of Ancillary Reimbursements at: +1 803 898 1040.